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COMMITTEE ON THE HEALING ARTS

REPORT 1970

ONTARIO

COMMITTEE ON THE HEALING ARTS

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Chapter 24 The Administrative and Policy-making Structure

The first two volumes of this report have examined the dimensions and structure of Ontario's health care system rather briefly, and the roles and problems of the various healing disciplines which participate in providing health care in greater detail. In this volume we deal with more general aspects of the provision of health care and consequently our attention is focused on the health care system. The chapters of this volume deal, then, with various aspects of that system.

It has always been one of the facts of human institutions that men gain knowledge more quickly than they learn to apply it. Knowledge about health care is no exception. Modern science has made massive breakthroughs in the understanding, prevention and cure of ill health. Scientific research has enabled us to postpone untimely death, implant artificial organs in bodies, and develop impressive chemotherapy. Certain diseases such as smallpox, diphtheria, poliomyelitis and typhoid fever have been almost completely conquered or eliminated. In short, the science and technology of health care have made dramatic advances.

The adaptation of organizations and techniques for the application or delivery of health care knowledge has been much less impressive. It is one thing to possess knowledge, but quite another to transmit and apply it broadly to a large community. A fundamental point, often overlooked, is that the complex institutional and organizational means of delivering care to patients is at least as important an aspect of human knowledge as any other. Methods of organizing and integrating health care services are as much a part of the technology of health care as is open heart surgery; knowledge, without means of applying it to the community's problems, is socially useless.

While there are no exact measures of the way in which the advances in medical science and technology have contributed to individual well-being, it seems fair to say that their largest early payoffs came in the area that is called public health. Though much of the improvement in health must be attributed to generally increased well-being resulting from rising standards of living and to the general spread in education, it is clear that the control of contagious disease, the purification of water supplies, the growth and improvement in public or publicly required sanitation systems including inspectoral services, and the undertaking of like measures that may be said to have improved the general environment, have been enormously beneficial to individual health. That the earliest benefits came in large measure through public health programs must be attributed partly to the fact that

the early gains in knowledge were of a kind that could be most readily applied through public health measures; it also must be attributed, in part, to the fact that the benefits of such measures could be rather clearly seen and, given public attitudes, could be feasibly, if not easily, undertaken. Whether the remedies for the newer environmental health problems that arise from increasing populations, the growth of cities, and the pollution of air, water and land in an increasing number of ways, will be adequately handled is not a matter for us to consider here.

It would be grotesque to suggest that there have not also been great personal benefits from growth in the provision of personal health care. One need cite only the great decline in infant and maternal mortality that is a result of great improvements in such care as well as of public health measures. Nor can it be said that there has not been great growth and adaptation in the means of providing such care. The growth of the public general hospital illustrates best, perhaps, the adaptation that has had the most pervasive effects in the making of these changes. Nevertheless, the view that the spread of improvement in the provision of personal health care is less wide and has been slower than is both warrantable and feasible is widely held.

That there should have been, at least in the earlier stages of development of modern medical science, a slower payoff from improvements in medical knowledge in the provision of personal health care than in public health may be attributed to a number of things. First, and perhaps most important, as we have already noted, the nature of the developments in health science was such that their first widespread applications were of a kind that lent themselves to public health measures—the services provided were what are described as public goods, goods which while conferring benefits on one individual also provide benefits to other individuals. Second, the perception of the benefits of public health measures was more clear than in the case of many, though certainly not all, services for personal health care: the choices made reflected both individual and collective choices in the circumstances of the time. Third, the provision of personal health care, involving as it does individual particular treatment, is a more complex matter to arrange than the provision of public health. While the early modern improvements made possible by medical science could be in large measure provided in the physician's office or the patient's home as had been traditional practice, later changes required a much modified structure. As we have noted in Chapter 5, the structure of the health care sector is not one that facilitates change in modes of delivery of personal health care.

Whatever the earlier circumstances, recent trends have been for a growth in the demand for personal health care on the part of the general public not only in absolute terms but also relative to all other commodities; there have been, in history, few cases in which a major sector of the economy has had its share in total personal expenditure increase by more than 50 per cent in the relatively brief period of twenty years. This growth is undoubtedly caused by many general factors including increasing standards of living and a greater awareness of the

benefits to be obtained from health care, but equally undoubtedly also by the ability of health science to provide greater individual well-being than ever before. In any event it has been accompanied by much concern, not only in Canada but elsewhere as well, about the availability of personal health care. Such concern is reflected in the growing number of official or semi-official inquiries into the delivery of health care and in expressions of opinion by private and public bodies or by members of the health professions and the general public alike. The need for efficiency and responsiveness to change in organization is always present; it becomes more urgent as the gains to be obtained from improved efficiency and responsiveness to change become larger.

The Need for Revision of Administration of Health Care

While it is beyond controversy that there is considerable room for improvement in the way in which health care services are provided for general use, we do not believe that any one artful rearrangement of the organization or reshuffling of the constituent elements of health care services can instantly produce a utopia for patients or practitioners. We are aware of the current tendency to indulge in glib but ill-defined talk about "the delivery system", which sometimes conveys an impression of substituting assembly line techniques for intimate professional procedures. We have no intention of proposing impersonal schemes for the regimentation of practitioners, nor do we regard health professionals as mere impersonal robots to be wedged against their will into arbitrary patterns of practice. We recognize also that, as communities organize their health resources into more integrated constellations of services, the consumer's need for personal attention must not be lost sight of in the search for more efficient systems. We do not envisage a monolithic system.

Nonetheless, we must emphasize that no other aspect of health care requires more attention than does the manner in which the health care system meets its ultimate objective, the promotion of good health of the general public. The crucial problems of how best to integrate the large congeries of health institutions and personnel cannot be neglected. Health care *is* and must be a giant industry; patterns of practice *do* affect services. It is axiomatic that some form of organization of services is essential, and that knowledge of health techniques can be made fully available to consumers only through sophisticated and well-designed patterns of care. In health services as in any other field of technology, the choice is not between organization or anarchy, but between superior and inferior alternatives of organization. The choices are by no means simple, but they must be made.

In our examination of the structure of the health industry in Volume 1, we noted the absence of an adequate coordinating mechanism in the health care system as it has existed. For reasons that do not need elaboration, it is apparent that the necessary adaptations cannot be those that place main reliance on the coordinating mechanism of markets and prices even though they continue to play an important role and indeed must be made to play a more effective one than now.

The alternative is that, in the public interest, a greater coordinating role be played consciously by some body. And since the matter is one of the public interest, that body should be the government, the body that most clearly and comprehensively represents the public interest. We note that over the last few years the provincial government and particularly the Department of Health increasingly have been assuming this role with most beneficial consequences.

In these circumstances, while a review of the structure of the Department of Health and related bodies dealing with health within the provincial government was not included in our terms of reference per se, it became apparent to us that the success of the changes that we propose elsewhere in our Report will depend greatly on the organization of the provincial government services and particularly those of the Department of Health. Accordingly in this chapter we propose a structure that will provide, in our view, the setting most conducive to the discharge of the public function in the provision of personal health care; we say relatively little about education in this chapter, even though that is a most important public responsibility, since education is treated separately in Chapter 26.

Our proposals are made in light of the fact that the activities of the provincial government in the health care field are vast. Traditionally it has managed or provided directly such specialized services as those of public health, Ontario Hospitals and tuberculosis sanatoria, and certain public laboratory facilities; more indirectly, it has, for quite some time, carried the responsibility for the major part of the financing of education of health personnel and the financing of hospital and other facilities. It has had also the responsibility for seeing that licensing and regulatory arrangements for various health disciplines are made and has carried out directly substantial inspectoral and regulatory functions.

More recently, it has taken on the major tasks of operating public hospital and medical insurance which are themselves major administrative operations; it has also increasingly assumed the role of coordinator of health services. Thus the province, within a consensus of the province's residents, has assumed the responsibility for: 1) assuring that some minimum quantity of the means of providing health care in the form of both trained manpower and facilities are available; 2) assuring that individuals within the province have reasonable access to some minimum quantities of health care services; and 3) assuring that health care services meet some minimum standards of quality. Management of these matters is no mean task.

The Legislature is, of course, responsible for all legislation; but it is with the executive responsibilities of the Cabinet or Ministry that we are chiefly concerned. In the main it is the Ministry that proposes legislation, and within legislation there is usually provision for wide areas of executive discretion. In addition, it is the Ministry that is responsible for administrative procedures, and it is the Ministry which must take the initiative in the planning process. Within our constitutional

system of parliamentary government, the ultimate responsibility of the Cabinet for the creation of policy and the achievement of public objectives is clear and undoubted.

A Functional Approach to Provincial Organization

We believe it useful, in order to provide a background against which our recommendations may be presented, to distinguish among the functions of policy-making, planning and coordinating, of administration, and of regulation performed by the Ministry. First, a policy-making, planning and coordinating function carries wide-ranging responsibilities. The preparation of new or amending legislation and its guidance through the Legislature and, of equal importance, the presentation of the budget and its estimates, which signifies much of the proposed lines of action within the legislation, are but a part, albeit a most important one, of this function. The legislative estimates and the budget provide only a general framework within which action is taken. There are, in addition, most important policy decisions to be made day by day in the exercise of the discretion left to the Ministry.

Policy is undertaken within some view of the way in which the future will develop and the way it is desired to shape it. Policy-making therefore must reflect some kind of a plan unless it is to be entirely passive and without direction. The question is not whether there will be planning or not but how much will be done, and how well and by whom. To be done well it requires the availability of a great deal of information and analysis of this information. In the health care system, in which coordination is not achieved by a market and price structure, it is necessary that someone is responsible for ensuring such coordination. While some elements of planning may be done separately from policy-making, the converse ought not to be true. Good policy is made within the light of the widest information and understanding that may be had, and at some stage, of course, the planning to be relevant, must have direction from the policy-makers. While one may think of policy-making and planning as being separable, the two are so interrelated that it is best to deal with them together.

Second, the Ministry is responsible for a very large administrative operation — the two largest administrative undertakings are those of the hospital insurance and the health insurance programs, but there are also others. While there must be elements of discretion involved in administrative procedures, they need not be of the kind that involve the objectives of the programs that the administrative apparatus is designed to handle. The administrative function primarily concerns the formation of an effective organization to perform the largely routine functions of carrying out programs that are specified more or less. From its nature the administrative function is one that requires a great deal of attention to organization and procedures. Its management can be most time consuming.

Third, in the health services, the Ministry is responsible for either performing directly licensing and regulatory functions in order to attempt to assure that the

quality of health care services meet at least some minimum standards, or seeing that appropriate alternative arrangements for delegating this function are made. The licensing and regulatory actions cover institutions as well as the membership of individual disciplines. Much of this function has been delegated to various professional groups; a considerable part, however, especially with regard to facilities, is done directly by the government.

As we have noted earlier, in this chapter we deal only with the coordinating function related to education.

Our present public institutional arrangements, which have evolved, over the years, in large part by a process of ad hoc addition with infrequent major restructuring, have dispersed the foci of these functions and have mixed them together in less than optimal ways. For example, we find that the Ontario Hospital Services Commission, a separate public institution, performs a substantial policy-making and planning role along with its administrative functions. At the same time, we find within the Department of Health itself the Ontario Health Services Insurance Plan, in which policy-making is more directly done by the Department of Health but in which there is also a very large administrative function. Within the broader government organization, we find that the Departments of Health, of Education, of University Affairs, along with university faculties, colleges of practice and various other bodies have been directly or indirectly involved in the education and training of health personnel with there not being, at least until quite recently, an adequately focused location of responsibility for the supply of health manpower. As matters have developed, the administrative function has increased so rapidly in recent years that public policy-making authorities, particularly in the Department of Health, have tended to become excessively burdened with day-to-day administrative detail. Coincidentally, the need for extending the planning and coordinating policy-making functions has grown.

Another major matter of concern in the institutional framework for administration and planning involves the roles of two major groups, the physicians and the public. The roles of these two primary groups, we believe, must be clarified and altered, a matter which to some extent has shaped our recommendations.

In our Introduction to Volume 1 and throughout this Report, the Committee has stressed the desirability of orienting the health system to the needs of society and of patients. The complexity of health technology and services has caused the professional practitioner to assume the leading role in the formulation of policy, and caused the consumer to assume a relatively passive role in the health system. But since the general objective of the system is to bring about optimum satisfaction or well-being to people, the centrality of the consumer's interest cannot be neglected. The needs of the community must be the paramount consideration in the shaping of the system; the role of the consuming public must be strengthened in the determination of health policy. In contemporary democratic society, the principal means by which the public may influence institutional policies and pro-

cedures is through government, but they may play more indirect parts as well. These considerations will be evident in the recommendations we make.

Similarly, with the interests of the entire community in mind, it is not desirable that healing practitioners in general, or any single professional group in particular, should assume the major role in the determination of policy to the exclusion or neglect of other interests. Certainly it is understandable that the medical profession, as the senior and most essential healing profession, traditionally has exercised great influence and power in the shaping of the health system. For the most part, organized medicine has not been lacking in social conscience, and the traditional power of the medical profession has been salutary in providing a high quality of health care. However, since a wide range of health services are now regarded as essential to any modern community, and since many new healing professions and occupations have emerged in this century as significant and necessary contributors to health care, it is no longer proper that the medical profession alone should possess the single most decisive influence on patterns and policies of health services. The Committee believes that it is important to the harmony and efficiency of the system to increase the influence of other interests, and particularly of the general public, in the performance of public functions related to health care.

It is, of course, desirable that due consideration be given to valuable professional traditions and to matters of professional concern which have a direct bearing on the quality of services. It is also important that the special knowledge and expertise of the medical profession continue to be brought to bear on policy considerations, particularly in regard to maintenance of quality in health care. But it is equally important to provide for greater participation than hitherto by the lay public and non-medical personnel in the shaping of the total health system.

In the light of the above, we make the proposals for the provincial public institutional structure which follow. We make our complete proposals in abbreviated form first, so that the overall structure may be seen and then we elaborate on them later.

A basic feature of our proposals is that the responsibilities for the administrative functions be separated, insofar as is reasonably feasible, from those for policy-making, planning and coordination. For the achievement of the coordination of health care, the fulcrum of the system must be the policy and planning function. While we regard as essential the separation of the policy formulation and administrative functions, we recognize that policy-making and planning are closely interrelated and should be inseparable.

We have said already that ultimate responsibility for decision-making and proposals for legislation must rest with the Cabinet. It is not possible to identify health care policy and planning with a single government department. Clearly the main department concerned is Health, but the Departments of University Affairs, Education, and Treasury and Economics (to name only three) are also involved, as may be the Department of Social and Family Services in the long run.

Policy-making and Planning

The Department of Health

We propose that the Department of Health retain, or in some measure assume for the first time, a very wide-ranging responsibility for the planning, policy development, financing and overall coordination of a large nexus of health services within the province, including delivery services and manpower questions. It should be the prime policy agency of the government for health in Ontario. As such it would require a very substantial research and planning branch with a large research capacity, to collect information and to process and analyze it, to examine the needs and requirements for current and future development, and to assess the consequences of measures and programs previously undertaken. To facilitate the discharge of these functions, we propose that the Department of Health separate off and delegate to commissions or boards such of its administrative functions as can be reasonably so delegated. Such delegation would not include the policy-making and related functions, excepting only those minor matters that cannot be separated from administration; and such commissions or boards would remain responsible for the execution of the policies of and report to the Department of Health. The Department of Health would retain the responsibility for policy and planning related to the affairs administered by these boards.

We believe, however, that the Department should retain administration of public health, partly because it involves business with municipalities (which function should be directly under government), and partly because of the importance of building up preventive and environmental medicine within the total nexus of health care. We have not made further recommendations about public health because it did not fall within our terms of reference. Some of the Department's other functions, such as inspection of certain sanitary facilities or pesticide control, might devolve to other departments, but we have not made a study of this matter and make no proposal.

The Coordinating Committee of the Cabinet on Health Education

We propose that there be a Coordinating Committee of the Cabinet on Health Education composed of the Ministers of Health, University Affairs and Education to examine and deal with educational and training matters of common concern, and to see that adequate account is taken of manpower as well as educational interests of the health professions and disciplines. As we have noted, not all health care policy-making and planning is located in the Department of Health. In particular, the Departments of Education and of University Affairs are responsible now for the education and training of many health personnel and we have proposed that they should assume the major responsibility for such education and training. The Department of Health will remain the department with the closest interest in manpower and service elements of training.

The Ontario Council of Health

We propose that a reconstituted Ontario Council of Health, appointed by the Prime Minister of Ontario, continue to function as an advisory body on health matters, that it be constituted of appointed members, knowledgeable about the professions, about the attitudes and wishes of the general public and about public bodies, that it have a full-time permanent chairman who is neither in the public service nor in a major health profession, that it be both advisory to the Minister of Health and make an annual report, which will be a public document, to the Legislature on the general state of health matters.

Such a body would be largely interested in the innovative, planning and coordinating aspects of health care. It would require a secretariat and some research capability, but we hope that it would be able to depend, in large measure, on the research facilities of the Department of Health.

Fee Negotiations Advisory Committee

We propose a Fee Negotiations Advisory Committee to advise the Minister of Health on the negotiations of published professional fee schedules for health services. The Minister of Health, however, would have the responsibility for negotiating such fees with the professional groups concerned.

Administrative Services

Ontario Health Services Insurance Commission

We propose that the administration of health services insurance schemes operated by the provincial government should be carried out by a Health Services Insurance Commission, responsible to the Department of Health; in particular, hospital services insurance and health services insurance would be administered by the Commission.

While the Commission would administer such insurance, it is most important that policy-making and planning in such matters remain with the Department of Health. The Department of Health then, within the government process, would determine premiums and benefits; it would be responsible for hospital planning and construction; and it would be responsible for budgeting.

Ontario Mental Hospitals Board

We propose an Ontario Mental Hospitals Board to operate the Ontario Hospitals and other facilities operated directly by the Province. We see this Board as being separate from the Ontario Health Services Insurance Commission since it will be engaged in the direct operation of a service, though some parts of that service may be transferred to the Insurance Commission as the service becomes an insured one. We also will recommend that care of retarded children who may benefit from

participation in an educational program should be transferred to the Department of Education.

As in the case of the Ontario Health Services Insurance Commission, we believe that policy-making, planning and coordination with other health services should remain a function of the Department of Health.

Regulation

Professional Licensure, Certification and Regulation

We propose that the function of licensure, certification and discipline be delegated, in the case of the senior professions, to professional licensing or certifying bodies as heretofore. However, we do suggest changes in the composition of these bodies. These proposals are dealt with in detail in Chapter 25.

The framing of the legislation that establishes these licensing and regulatory bodies would continue, of course, to be a matter for the Department of Health. In addition, we have recommended that all regulations made by these bodies be subject to approval by the Lieutenant Governor in Council. We see the Department of Health as being the authority that scrutinizes these regulations for recommendation to the Lieutenant Governor in Council (with advice being offered to the Department by the Ontario Council of Health) in cases which it deems appropriate.

Health Disciplines Regulation Board

We propose in Chapter 25 establishment of a Health Disciplines Regulation Board as an administrative tribunal with quasi-judicial powers for licensure, certification and regulation of all but the senior health disciplines. This Board would have and obtain advice from a number of divisions, one for each discipline, on matters of registration, disciplining and regulation. The functions and structure of this Board are dealt with at length also in Chapter 25.

Health Facilities Board

We propose a Health Facilities Board to administer the legislation and the regulations made thereunder, which we have recommended for the regulation of private medical laboratories, dental laboratories and pharmacies, and the sale of drugs and poisons; and to administer the regulations concerning radiological facilities, which have already been established under the Public Health Act.

The regulations made under this legislation either would be made by the Minister of Health or would require the approval of the Lieutenant Governor in Council—in the latter event scrutiny and recommendation by the Department of Health before approval was given would be required.

Health Commissioner

We propose also, in our chapter on regulation, the establishment of an office of Health Commissioner. The Health Commissioner would have broad powers of investigation into the circumstances of individual complaints on the part of members of the public and members of practising professions and disciplines, arising from the manner of control and provision of health care. He would have the authority to publish his findings, if he deemed it necessary, both on the general working of the regulatory and control systems in the provision of health care and on cases of individual complaints. This proposal is described more fully in Chapter 25.

Regional Structure

We have few proposals to make about the regional structure of government or government-sponsored bodies since we have not made a study of them. However, as a matter of principle, we favour local and regional participation in the provision of a service such as health care, and support local participation in matters of public concern. Though we do not have general proposals to make about the regional structure for policy-making and administration, we examine some of the features of the provision of health care within a regional framework later in this chapter.

Summary — Government Structure

Thus the main elements in the provincial government structure, excluding the educational arrangements, would be:

1) Policy, Planning and Coordination
   a) Department of Health
   b) The Coordinating Committee of the Cabinet on Health Education
   c) The Ontario Council of Health
   d) Fee Negotiations Advisory Committee
2) Administrative
   a) Ontario Health Services Insurance Commission
   b) Ontario Mental Hospitals Board
3) Licensing, Certification and Regulation
   a) Professional licensing, certifying, and regulating colleges or boards
   b) Health Disciplines Regulation Board
   c) Health Facilities Board
4) Grievance Investigation
   a) Health Commissioner

Details of the Rationale of the Proposed Structure

Policy-making and Planning

We elaborate now the special considerations which led to the recommendation of this administrative and policy-making structure.

The Department of Health

It is clear that the Department of Health is so overburdened with administrative functions already that a very large part of the time and attention of the Minister and the senior civil servants in the Department must be devoted to these matters, to the detriment of the performance of the policy-making, planning and coordination function. Since we propose that the latter function be expanded, the problem would become all the greater if the Department were not relieved of many of its administrative obligations.

If the senior officials of the Department of Health are freed from the relatively routine concerns of administration, the Minister and his senior advisers will be able to devote their attention to fundamental matters of policy, planning and coordination. Furthermore, it is a familiar principle of both private and public administration that administrative convenience, rather than a clear perception of the public interest, often shapes the procedures to be followed in large organizations. Bureaucratic convenience, habit, or even intransigence may inhibit or prevent implementation of change in the system. Clearly this situation is to be avoided wherever possible. There is an urgent need to facilitate rather than inhibit change in Ontario's health care system.

Two areas of policy-making need to be stressed. First, there is the matter of manpower supply and the supply of facilities such as hospitals and many other institutions, which must be a prime concern and responsibility of the Department; and second, there is the matter of facilitating adaptation in what we shall call, for want of a better term, the system of providing personal health care to the public.

It appears to be a widespread popular misconception that health manpower supply, at least of the senior professions, is determined by the major healing professions themselves. For example, we have frequently encountered the assumption that the supply of physicians and dentists is determined and controlled by the College of Physicians and Surgeons of Ontario and the Royal College of Dental Surgeons of Ontario. This assumption is, of course, erroneous. These colleges are indeed licensing bodies possessing certain powers, delegated to them by the Province, to accept or reject applicants for licensure. But these discretionary powers are limited; applicants for licensure who have been educated in Ontario are very rarely rejected, and in recent years the colleges of practice have had little influence and no direct control over the numbers of graduates from this province's medical or dental training programs. In essence the numbers of these trained graduates are determined by the number of university places available for their education, and

the number of university places is in turn determined by the availability of public funds to finance the creation or expansion of educational facilities.

In the last analysis, and with the exception of immigrant practitioners, health manpower supply is determined by government decisions and the availability of public money for education; it is a matter of social choice through the political system. Manpower supply is, and in our opinion ought to be, a matter of public decision and government responsibility.

The effect on manpower of the licensing policies of professional licensing bodies in recent years has been greater for professional personnel coming from outside Ontario. In our view, the standards required of such personnel and the procedures followed, though in general established by the licensing bodies in what they view as the public interest, have been, in some cases, unnecessarily restrictive. It should be noted, however, that in some professions the numbers coming from outside Ontario have been very large, and the effects of licensing policies and procedures on limiting manpower supply have been, except in one or two professions, relatively minor compared to the limitations imposed by the size of our own educational and training facilities. Our recommendations on licensing procedures are presented in Chapter 25 and in the individual chapters of Volume 2.

Until recent years at least, the provision of an adequate supply of health manpower has received inadequate attention and has tended to be a "no man's land" in which government, colleges of practice, voluntary associations, and university educators all have had some interest, but in which no single public or private agency took a sufficiently general overview of the problems or provided sufficiently bold leadership in solving those problems. It is scarcely surprising in such circumstances that there have been persistent shortages or scarcities of trained manpower in various professions and occupations, and that the time lags in overcoming manpower deficiencies have been long.

It is apparent that, in addition to manpower requirements, an adequate supply of hospitals and equipment and many similar facilities is vital to provision of good health care. It is not necessary to elaborate on our belief that the quantities, locations and forms of such facilities is also a Departmental responsibility.

Just as the quantities of health manpower and health care facilities are important, so are their forms, the roles and the methods of organization of these health care resources. We have noted in various places, and especially in Chapter 5, that the structure of the health care industry is such that it may not be shaped, and adaptations in it may not take place, in a way likely to assure the most effective use of the manpower and other inputs without there being some coordination of its parts and the means of facilitating adaptation. In these matters, the Department of Health has a major role to play, not as a central monolithic controlling body, but as a body which facilitates innovation in ways of providing health care, and which promotes the spread of new ways of providing health services which have been demonstrated to be effective.

There is an extensive and rapidly growing literature providing suggestions on ways in which the "efficiency" of the health care system as a whole may be increased. Suggestions for change that have been made include changes in roles of various types of health care personnel, changes in the types of facilities available for inpatient care, improvements in the facilities for and modes of delivery of outpatient services, and the introduction, or better the more widespread use, of incentives to encourage adaptation.

Unfortunately, it is not the rule but rather the exception that the benefits to be obtained by these suggested measures are evident a priori. Commonly, the insufficient certainty that an innovation will work out satisfactorily makes it prudent to try it on an experimental basis before a major commitment is made. In fact, as we have noted many times, such experimentation is fairly widespread in many parts of the world. That much of the experimentation appears to have been inconclusive suggests the great need for better evaluation techniques than we have had.

Innovation of this kind can be helped in a number of ways. First, there is the perception of the possibility of new ways of doing things, which perception may come from either private or public bodies. Second, financial assistance may be necessary for a pilot project and also may be necessary for making proper evaluations. Third, it may be necessary to see that statutory restraints or licensing and regulatory requirements do not hamper or even prevent the trial of the innovation. Fourth, if the innovation should prove worthwhile, its widespread introduction may require new legislation or changes in regulatory practice; it may require the allocation of funds; it may require the dissemination of information.

We see an important role for the Department of Health in facilitating these kinds of activities. It is partly for this reason that we believe the policy-making and coordinating function should be centred in the Department of Health. For example, in the review of hospital budgets, it may decide to provide the finance necessary to undertake a pilot project. It may see that already existing experiments, as well as new experimental projects, are evaluated as objectively and comprehensively as possible. It may encourage by financial and other means the adoption of proven innovation. It may experiment with and develop financial and other incentives to encourage efficient practice by smaller decision-making units.

The Research and Planning Branch

It is obvious that manpower and facilities planning and encouragement of efficient use of manpower and other resources are by no means simple matters. Effective manpower and resource planning requires concerted attention to the following six basic considerations at least:

1) There must be careful and continuing study of the total health care system, and the determination of the levels and types of services it is socially desired to have available.

2) There must be constant examination and re-examination of the roles of all types and categories of health manpower to obtain the most effective and complementary utilization of skills and the most efficient division of labour between various levels and types of personnel.

3) There must be a quantitative assessment of existing manpower and facilities, and precise estimation of the adequacy or inadequacy of these resources to meet present and future needs.

4) There must be a conscious assignment of priorities to be applied to the use of scarce resources after deliberate public decision-making concerning the community's needs, and determination of appropriate priorities to be pursued in overcoming deficiencies in the quantity and quality of services desired.

5) There must be recognition that manpower research and planning, like other aspects of health research and planning, must be a continuous rather than an intermittent process.

6) There must be coordination of manpower policy with educational policy to ensure the training of sufficient numbers and appropriate categories of practitioners to meet public requirements.

To carry out its policy and planning functions, the Department of Health will require a Research and Planning Branch of substantial proportions. This Branch should include within it sufficient facilities, personnel, and expertise to carry on extensive and continuous research and collection of data on present and future requirements for the health care system. It should make projections and recommendations which will facilitate the formulation of current policy in the light of firm current evidence and informed estimates of future needs. It must play a substantial role in the encouragement of pilot projects and their evaluation. It is our view that the Research and Planning Branch should be not an appendage of the Department of Health, but a central and leading part of the Department.

We note in passing that one of the great problems in the health care field is the inadequate statistical and other information base. While we do not see the Research and Planning Branch as being itself a collector of primary statistical data, we believe it most important that it promote the collection and processing of such data elsewhere; failing that, the Branch should undertake the task itself.

It is evident that the existing Research and Planning Branch of the Department has expanded in size and scope in recent years and done admirable work in the compilation of data and advising the Minister. Nonetheless, the work of this Branch must be facilitated and expanded to ensure that adequate planning resources and expertise are available to the Minister and the Cabinet.

We wish to point out that since it is desirable that no single profession exercise undue influence over policy there appears to us no necessity that the Minister

of Health, the Deputy Minister of Health, or the Director of the Research and Planning Branch must invariably be a physician. There is no apparent reason why other non-medical personnel should not occupy these positions and fill these roles satisfactorily. Certainly physicians should not be excluded from such positions, but neither should non-medical personnel be excluded.

The Ontario Council of Health

In 1966 the provincial government established the Ontario Council of Health as an advisory body. This step was taken in recognition of the need for long-range health planning and for expanded planning facilities. The Ontario Council of Health has done fine work in laying the foundation for a more coordinated health system and enabling public authorities to take a long-range view of health needs. While we recognize that the establishment of the Council constituted an important step towards improved policy and planning arrangements, we believe that the time has now come to change the functions and organization of the Ontario Council of Health in ways that will make it still more effective.

To facilitate the policy-making and planning functions we propose that the Ontario Council of Health should be reconstituted along new lines. The new Council of Health should continue as an advisory body. It should provide the Minister with assistance on planning matters and informed advice and recommendations reflecting in the broadest sense the public interest in health services. It should be an appointed body, intended to provide the Minister with independent advice from outside the orthodox channels of the public service. The Ontario Council of Health should be widely representative of both the lay public generally and experienced experts in the health field; however, it is intended not to provide representation of particular professional interest groups, but to provide a continuing flow of information and advice from people knowledgeable about community and individual needs as well as about the means of providing health care.

The size and constituency of the new Council should be similar to that of the present Council. The Chairman of the Council of Health should not be a member of the Department of Health; he should be an independent adviser to the Minister on a full-time basis. Because this new Council should be intended primarily to represent many points of view, the Department will require only one member on the Council, and that representative should be the director of the Research and Planning Branch. This arrangement is designed to promote the fullest liaison and cooperation between the Research and Planning Branch and the Ontario Council of Health. The Council is intended to supplement and complement the work of the Research and Planning Branch, and should have complete access to the staff and documents of that Branch. In addition, the Council will require a full-time secretariat and some research personnel of its own. This research secretariat need not necessarily be large if satisfactory means of communication are established between the Council and the Research and Planning Branch, but it is desirable

that both the Council and the government have access to outside advice and staff who are not members of the government service.

The importance which we attach to the work of the Council requires that it be assured of adequate and independent funds to carry out its functions.

Sufficient money should be available to enable the Council to expand its research secretariat if that should prove necessary, and financing should be available to enable the Council to commission external research projects as the Council deems necessary.

In addition to providing advice and recommendations directly to the Minister, an important duty of the Council of Health should be to present an Annual Report not merely to the Minister but to the public at large. The Annual Report should be tabled in the Legislature annually. It is desirable that the Report receive full public attention and be the focus of continuing public discussion of the adequacy of health services. The Legislature may find it appropriate to refer the Report of the Council to a standing legislative committee for review during each legislative session. The Council should also publish such research studies and other documents as it deems appropriate.

The Coordinating Committee of the Cabinet on Health Education

It is clear that health manpower policy must be coordinated with policies relating to the education of health personnel. Readers of Volume 2 will have noted this Committee's view and recommendations that control of the education of healing personnel should be in the hands of educational authorities rather than in the hands of institutions providing health services, or professional voluntary or regulatory bodies. Fundamentally, we believe that education should be under the control of knowledgeable educators. It is the responsibility of government to provide the necessary funds for educational facilities and to make the decisions regarding the development of additional educational facilities. Specific matters of educational policy are dealt with more extensively in Chapter 26.

Education of the senior health professions should be under the jurisdiction of the Department of University Affairs. This Committee does not contemplate any major changes in this regard.

However, changes are required in the arrangements relating to the Department of Health. We believe that many disciplines now trained in hospitals and the expanding numbers and categories of health personnel now being trained in the Colleges of Applied Arts and Technology should be under the control of the Department of Education, as should the education of non-degree nurses and nursing assistants. This change in the arrangements for nursing education, discussed previously in Chapter 10, constitutes a major shift in the control of training programs. It will place an increased burden of responsibility for health personnel

on the Department of Education and, we believe, bring about a constructive change in nursing education.

In considering the question of the education of those occupations presently undertaken in hospitals and by service agencies, the Committee recognizes that a number of questions arise regarding the consequences of transferring such programs to educational institutions. The transfer must take place gradually rather than abruptly, and must in some measure be consequent upon additional research into the optimal roles of the various healing groups. Research is required particularly with regard to the relative costs to society of alternative educational arrangements, the relative effectiveness of the graduates in performing their tasks, the impact on numbers entering and remaining in the various occupations, the long-term usefulness of the graduates to the entire health system, and their ability to adapt to changes in healing technology and in society's needs for health care. Therefore, we again stress the importance of continuing research into occupational roles and the need to coordinate educational policy with health manpower policy.

It is clear that effective means must be found of integrating the work and concerns of these three departments of government—the Departments of Health, of University Affairs, and of Education. With this in view, and in order to ensure that the interest of the Department of Health in manpower and educational policy be represented fully, we see the Coordinating Committee of the Cabinet on Health Education, composed of the Ministers of Health, of University Affairs, and of Education, reviewing and coordinating educational policies which directly affect the health care system. In particular, this Coordinating Committee should review the impact of educational policies on manpower supply, and on educational facilities (such as teaching hospitals) in which a substantial service element is involved in the training of personnel. It seems desirable that the existing coordinating committee, composed of the Deputy Ministers of these departments, should remain in being as a subcommittee of the major Cabinet Coordinating Committee. The Committee of Ministers should have a permanent and probably full-time secretary charged with the responsibility for seeing that relevant items are placed on the agenda of the Cabinet Coordinating Committee. It is also our intention that the recommendations of the existing Committee on University Affairs relating to the education of the health disciplines should come to the attention of the Cabinet Coordinating Committee since they affect the university academic programs in health in important ways.

To provide technical advice on matters of educational policy pertaining to certain occupations and groups, we propose the creation of various educational advisory committees. These committees should report to the Minister of Education. The committees' functions should be to advise on matters such as curricula and length of training programs. All appointees to these educational advisory committees should be selected by the government on the basis of knowledge and personal merit, and not as representatives of interest groups.

Fee Negotiations Advisory Committee

We must now say something more about the proposed arrangements for fee negotiation. In return for providing personal services to the general public, the common means of receiving payment by members of many health professions is by fee for service. It has become the practice for voluntary professional associations to publish fee schedules which give in detail suggested fees for different individual health services. We take, as an example of such schedules, the Ontario Medical Association publication entitled Schedule of Fees, April 1, 1969.[1] In its preamble it is stated that "The tariff should be used as a guide by the practising physician" and "The schedule is revised in consultation with the Sections and represents a reasonable average return for services rendered by medical doctors licensed to practice in the Province of Ontario". It is further stated that "The principles governing proper professional charges are now incorporated in the Regulations of the Colleges of Physicians and Surgeons of Ontario". The College has in the past endorsed the OMA Schedule of Fees in the words of the preamble to resolution 3-c-11-66, "Whereas the OMA Schedule of Fees is regarded as a reasonable average standard value of professional services and an adequate return for these services",[2] though we do not know whether the College has endorsed the OMA Schedule of Fees presently in effect. The most recent affirmations of the College that we have are in "Principles governing proper professional charges" in the *Warning Notice* sent to all practitioners in 1969.[3] The medical profession has taken account of the financial circumstances of patients in charging fees and the *Warning Notice* issued by the Council of the College of Physicians and Surgeons of Ontario, 1969, states explicitly after listing the principles governing proper fee charges that "the foregoing factors should be weighted by financial circumstances of the patient". In the past fees have varied for persons depending upon their circumstances; the poor, for example, have received care without charge. More recently, and particularly with the development of privately and publicly financed health insurance schemes, it has become much more the practice, at least for insured services, for a uniform fee for a given service to be charged by most physicians to everyone. However, there is still scope for taking account of special circumstances or special skills.

The Committee's interests in the matter of fees are two-fold. First, there is the general level of fees and, second, there is the structure of fees. On the matter of the general level of fees the Committee expresses no opinion about the adequacy or inadequacy of the fees in past or present fee schedules. We do note, however, that the members of professions that are licensed or similarly regulated, do have a monopolistic power conferred upon them by the prohibition of other members of the community from practising the arts and skills of each particular profession. The fee schedules have been established unilaterally by the voluntary associations

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[1]Ontario Medical Association, *Schedule of Fees, April 1, 1969.*

[2]College of Physicians and Surgeons of Ontario, *Report,* July 1967, pp. 19-20.

[3]*Warning Notice Issued by the College of Physicians and Surgeons of Ontario, 1969.*

of the professions. In these circumstances, there is always the possibility of conflict between the economic interests of the members of the profession and the general public interest. In our view, when the Province confers certain powers on fee charging professions that indirectly enable them as a group to establish a general level of fees, it is appropriate that the Province should participate in the establishment of the fee schedule. In saying this, we should add that we believe it to be in the public interest as well as in the interests of the professions that healing practitioners receive adequate and attractive rates of remuneration. At the same time, we believe that the public interest must be protected, and must be seen to be protected.

A second characteristic of the fee schedules is that their structure affects the allocation of manpower among the various specialties of the profession and also affects the types of services that will be provided by an individual member of the profession. We do not need to elaborate that the financial reward is an important factor among several affecting the choice of specialty by an individual. It has been alleged to us that the fee structure has affected also the division of professional services between preventive and curative types of services; we have been told that fee schedules have encouraged the practice of curative medicine to the detriment of the practice of preventive medicine. How much truth there is in this latter suggestion we do not know, but the assertion is made commonly enough that there appears to be some justification for it.

For these reasons we believe it essential that the government, on behalf of the public, should participate in the establishment of fee schedules. We realize that the establishment of such schedules is a most complicated matter; we realize further that governments, which are involved in the financing of health insurance schemes, will have biases of their own in attempting to limit costs of such schemes. Accordingly we propose the creation of a Fee Negotiations Advisory Committee to advise the Minister of Health in his financial dealings with the fee charging professions. We believe, however, that the actual negotiation of such fees should be a matter for the professions and the Minister himself. The fees negotiated should ordinarily be considered the full fee to be charged by the practitioner.

Administrative Services

We need add only a few words about the administrative bodies which we propose. The assumption by the Province of both hospital insurance and general health insurance schemes carries with it large administrative burdens. These schemes now constitute a very large and complicated operation for the collection and disbursement of money, the authentication of claims and a great number of similar tasks.

Ontario Health Services Insurance Commission

In general, the present Ontario Hospital Services Commission and the Ontario Health Services Insurance Plan have met the considerable demands which have been placed upon them and have performed satisfactorily. However, the point should not be lost sight of that there is at least a potential danger in permitting a proliferation of administrative boards and commissions. The OHSC and OHSIP, together with the Health Insurance Registration Board (HIRB), have been created at various times to administer specific public programs, but the time has now come to recognize that these organizations are designed basically to perform a single function: to administer health insurance schemes. There is no apparent reason why these various insurance schemes should be regarded as distinct or kept apart from each other and administered by separate bodies. Since we regard health care as a single system which requires cooperation, and since we regard the provision of health insurance as a single operation, we believe that the functions of OHSC, OHSIP and HIRB should be combined into a single operating agency. We believe that the gains to be achieved, both in economy of operation and in consistency of practice, by placing the administration of all public insurance services in one place, are substantial.

Thus we propose that there should be created a single commission, the Ontario Health Services Insurance Commission, to administer all aspects of health insurance schemes, and that the functions of OHSC, OHSIP and HIRB should be combined into one administrative unit. These functions should be placed outside the line responsibility of the Department of Health and located under a single independent administrative Commission, similar to OHSC in its present arrangements in that it should report to the Legislature through the Minister of Health. The new Ontario Health Services Insurance Commission should have less policy-making authority than OHSC now has and should be concerned primarily with administrative procedures.

The functions of the Ontario Health Services Insurance Commission should be to collect insurance premiums, but not to set the rates of insurance premiums since that is a matter of public policy which must remain under the control of the Minister and the Cabinet. The Commission should receive and approve claims, make payments, and keep detailed records of its transactions for administrative and research purposes. Like OHSC in the past, the Commission should have facilities through which it can advise hospitals on operating efficiency and optimal utilization of services and personnel. The Commission should be responsible for determining public financial liability under insurance arrangements, and should be charged with the application of policy (set by the Cabinet) under the appropriate legislation and the regulations under that legislation.

With the Commission established primarily as an administrative body only, policy, including financial policy, review of hospital budgets, construction of public hospitals, convalescent units, rehabilitation units, and the determination of fee schedules and means of payment and the like, would be reserved to the

Minister of Health and the government. On matters of routine or minor policy, the Commission must have some discretion, but overall policy matters must remain explicitly in the hands of the Cabinet.

In order that the economic efficiency of the health system and the insurance scheme should come under constant review and scrutiny, the Commission should perform certain research functions. The Commission may require a small research staff, or have access at least to the facilities of the Research and Planning Branch of the Department of Health so that personnel utilization studies and studies of hospital practices may be performed on a continuing basis. Such studies may make a significant contribution to the economic efficiency of the system.

Ontario Mental Hospitals Board

In order further to relieve the Department of administrative responsibility and in recognition of the changes that are coming about in the treatment of the mentally ill, separate arrangements should be made for those hospitals now administered through the Mental Health Division of the Department of Health. The changes taking place in the field of mental health are discussed in Chapter 28. They involve a movement of much health care away from the large Ontario Hospital of the past and the provision of treatment in local and more community-oriented facilities of other sorts outside the large provincial system; they have made the custodial aspects of mental health less a factor than they were before. At least for some time, however, and especially for those with severe long-term illness, there will be a place for the provincially operated hospitals, but we see no reason why they should continue to be operated directly by the Department of Health. The administration of these hospitals, then, should be changed from direct line control of the Department of Health to a separate Ontario Mental Hospitals Board which should include laymen; in the long run it may be desirable to establish further local boards on a regional basis as required. This Board's function should be limited and primarily administrative; establishment of policy should remain the responsibility of the Department of Health.

Care of retarded children, other than those whose needs are not primarily health care, should be transferred from the Department of Health to the Department of Education. We realize that an element of custodial care may be involved in the arrangements for the mentally retarded, but the Department of Health has no particular expertise in general custodial care. As an alternative, the Department of Social and Family Services might look after the retarded, particularly the care of the adult retarded.

Regulation

Since regulation of health personnel is dealt with at length in Chapter 25 we say no more about it here. However, we propose also the establishment of a Health Facilities Board and we should discuss it briefly.

Health Facilities Board

Elsewhere in this Report we have recommended the enactment of legislation and the making of regulations to apply to private medical laboratories and dental laboratories. We recommend also that the legislation regarding the sales of drugs and poisons and governing the operation of retail pharmacies be placed in a statute separate from that which deals with the profession of pharmacy. Finally, there are in effect now the regulations under the Public Health Act applying to radiological facilities and equipment.

The purpose of the statutes and of the regulations thereunder is to set some standards for the physical facilities, to see that personnel and management with the appropriate training are engaged in these facilities, and to see that procedures are followed in accordance with the statutes and the regulations. The task of performing these regulatory functions is a specialized type of task with some common elements for all four of the types of facilities that are involved. We believe it most appropriate that this task be performed by a specialized agency whose function will be primarily administrative. Accordingly we propose the establishment of a Health Facilities Board.

Regional Organization of Health Services

Finally, we come to the matter of the regional organization of health services. This matter is of considerable importance owing to the significant gaps in some of the health services in particular regions. Moreover, it is evident that the problems of various regions of the province vary. The services and facilities that are appropriate for large metropolitan centres may not be suitable for smaller urban centres; and predominantly rural districts will have requirements of their own. We see, therefore, that there is a place for some type of regional organization in the province. However, we have not made a study of the matter and accordingly have little to say about it. We should like to note the developments that have taken place to date, however—developments which appear to us to hold considerable promise.

Recently, several steps have been taken by provincial authorities towards overcoming some of the most acute problems of maldistribution of services and towards establishing a regional structure for health care.

Early in 1969, the Committee on Regional Organization of Health Services of the Ontario Council of Health made a report to the Council.[4] This report recommended:

1) That the organization and development of the several interrelated health services be carried out on the premise of providing the best possible total health services for the people of Ontario within a regional organization.

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[4]Report of the Committee on Regional Organization of Health Services, to the Ontario Council of Health, January 31, 1969, unpublished, mimeo.

2) That such regional health organization should be based, in general and where specifically applicable, on university spheres of influence and interest and that every reasonable means be taken to assure that the health sciences centres of these universities are capable of assuming an active dual role in education and research, as their prime function, as well as in continuing education, retraining and service consulting in both the professional and semi-professional aspects of the total health services for which they may be totally or in part responsible.

3) That the implementation of a regional plan for total health service be based on at least two levels of authority and responsibility, the region and districts within each region.

4) That councils be established at the Regional and District levels to exercise the authority and responsibility delegated by the provincial government.

5) That the provincial government have the role of providing policy guidance, of setting standards and of assessing the overall effectiveness of the system.

6) That the Regional Council have the role, based on provincial guidelines, of planning for the provision of health services within its region, to ensure that efficient, effective and economic use is made of available manpower, facilities and funds.

7) That the District Council have the role, based on provincial guidelines and on the regional planning program, of organizing the provision of health care for the residents of the district, and of coordinating operational functions.

8) That a detailed study be made of methods of implementing a system of regional organization for Ontario.

These proposals were consistent with the recommendations of the Ontario Committee on Taxation, 1967 which urged the establishment of a general regionalized structure for governmental services in Ontario.[5]

Under the scheme outlined by the Committee of the Ontario Council of Health, the provincial government would continue to have overall responsibility for the health of the people of the province. The provincial government would also continue to have responsibility for the delineation of health regions and districts; the overall planning and guidance for the provision of health services (taking into account the particular needs of each region); the provision of consultative services to the Regional and District Councils; the collection and analysis of data for use in evaluating the effectiveness of the health care system; and the

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[5]*Report of the Ontario Committee on Taxation*, Queen's Printer, Toronto, 1967, Vol. II, Ch. 23.

maintenance of financial control through a centralized administrative authority (the Regional and District Councils were not intended to be executive bodies).

In accordance with these recommendations, the Minister of Health announced in July 1969 that the Department intended to proceed with the implementation of a regional scheme.[6] The Minister announced that seven regions would be created, five in southern Ontario and two in northern Ontario. In the south, the regions would be based on the health sciences centres at the University of Ottawa, Queen's University (Kingston), the University of Toronto, McMaster University (Hamilton), and the University of Western Ontario (London). The northern regions would be administered from Thunder Bay and from Sudbury.

The announcements of the Minister of Health in July 1969 constitute important and encouraging steps towards overcoming the maldistribution of health services in Ontario. We are mindful that such schemes always involve public expense, and that continuous experimentation will be required to improve the access of all citizens to health care. We are also mindful that wherever any significant group of citizens is deprived of essential health services by reason of barriers of access to such services, serious hazards to health and social inequities exist which no civilized community can passively accept. As we noted in Chapter 4, it is difficult for a government to justify compulsory contributions for health care insurance on the part of persons for whom health care is difficult to obtain. Continuous review of the adequacy of levels of service and access to service will be required by both the Ontario Council of Health and the Regional Health Councils.

We have no doubt that the establishment of health regions and districts will help to identify and overcome these problems. We believe that after study of particular regional and district needs, the Council of Health and the Department of Health should establish certain minimum levels of service which should be assured to all citizens insofar as may be feasible.

As we have indicated in Chapter 27 we anticipate that hospital planning and the creation of hospital facilities will continue to be carried out on a regional basis. We would like to see increased integration of all health services, including hospital services. Therefore we believe that hospital planning on a regional basis should not be done separately from the development of all the health services under the Councils of the health regions and should be integrated with the overall program of the Regional Health Councils.

Recommendations

It has been convenient, in this chapter, to place our recommendations in one section. These we now make.*

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[6]Ontario Department of Health, Press Release, July 16, 1969.

*See minority opinion, pp. 210-217.

Recommendations:

293 That the Department of Health be relieved of direct administration of health programs insofar as feasible, and that policy-making, planning and coordination be its main function, including reviewing and setting of hospital budgets, deciding on coverage under publicly financed health insurance, deciding on standards of services provided under insurance, and deciding upon manpower needs and goals.

294 That a substantially enlarged Research and Planning Branch be included in this Department to undertake research and the analysis of background data and information necessary for policy formulation.

295 That the Ontario Council of Health be reconstituted and that it continue to make recommendations directly to the Minister of Health. The membership of this Council should be similar to that of the existing Council of Health, except that a) the Chairman should not be a member of the Department of Health; b) the representative of the Department of Health on the Council should be the director of the Research and Planning Branch; and c) the Chairman, at least, should be a full-time member of the Council.

296 That the Ontario Council of Health should publish an Annual Report dealing with the current and forward view of the availability of health services and the working of the health care system, generally, as well as such research studies and other documents as it deems appropriate.

297 That adequate and independent funds be made available to the Ontario Council of Health by the Government of Ontario.

298 That the Ontario Council of Health should have its own secretariat and research staff, and have authority to commission external research projects.

299 That there should be a Coordinating Committee of the Cabinet on Health Education, composed of the Ministers of Health, University Affairs and Education to review and coordinate educational policies which directly affect the Department of Health and, in particular, to review the impact of educational procedures on manpower supply, and of educational facilities in which a substantial service element is involved.

300 That support for health sciences education in the universities remain the responsibility of the Department of University Affairs, and that the Department of Education be responsible for the educational programs for nearly all other health disciplines.

301 That individual committees, advisory to the Minister of Education, be established for each of the health disciplines educated in institutions

under the jurisdiction of the Department of Education, and that each committee be composed of members of the occupation whose educational program is directly concerned, as well as members of related occupations where applicable, and other members who are capable of contributing to the relevant committee; that the committees' functions should be to advise on matters such as curricula, length of program, and training standards of each health discipline. Each appointee to these educational advisory committees should be selected on personal merit.

302 That a Fee Negotiations Advisory Committee be established by the Ontario government to advise the Minister of Health on the negotiation of professional fee schedules for groups in the health system who receive their income primarily from fee for service, whether or not the services of a specific profession are covered by publicly financed health insurance programs. The Fee Negotiations Advisory Committee should not be composed of professional health personnel. The negotiations themselves should be the responsibility of the Minister of Health and his senior officials.

303 That the present Ontario Hospital Insurance Commission, Health Insurance Registration Board, and Ontario Health Services Insurance Division be merged under an Ontario Health Services Insurance Commission, reporting to the Minister of Health, which would administer hospital and medical insurance programs. This Commission should be an administrative body only. Policy, including financial policy, review of hospital budgets, approval of construction of public hospitals, convalescent units, rehabilitation units, determination of fee schedules and means of payment, policy on drugs, and the like, should be established through the Department of Health.

304 That an Ontario Mental Hospitals Board be established for the supervision and administration of Ontario Hospitals and allied mental health services operated presently by the Department of Health. Such a Board should include lay members; if feasible further boards should be established on a regional or local basis as required. The Department of Health must, however, remain responsible for policy matters concerned with the provision of mental health services generally.

305 That a Health Facilities Board under the aegis of the Department of Health, be established to administer the legislation and the regulations concerning medical laboratories, radiological facilities, dental laboratories, the sale of drugs and poisons, and the operation of pharmacies.

306 That care of mentally retarded children, whose needs are not health care, be transferred from the Department of Health to the Department of Education.

307 That after study of local health care needs by each of the Regional Health Councils, the Department of Health should establish acceptable minimal standards for the provision of health care, and take appropriate steps for the implementation of these standards such as providing incentives to induce personnel and resources to locate in underserviced areas, and establishing satellite health clinics and demonstration projects involving both medical and paramedical personnel.

Chapter 25 Regulation of the Healing Arts

General Background

Traditionally, the senior professions in the healing arts have been characterized by self-regulation. Moreover, historically, and with the possible exception or qualification of the "drugless practitioner", the impetus for regulation has come from the professions or occupational groups themselves, always, of course, expressing concern for the public good. In recommending reform or even merely rationalization of the regulation of the healing arts, the Committee has taken care to be mindful of the historical evolution of the professions and occupational groups involved. As a result the Committee's view favours a policy of maximum self-government, consistent with the public interest. But in stating that policy, we must never lose sight of the fact that the right to such self-government is a delegation from the state by its popularly elected legislature and imposes on the profession or group a corresponding trust to see that the right is exercised in the public interest. It cannot be overemphasized that primacy of the public interest must be the cornerstone of any regulatory structure. Where there is conflict between the interests of the public and the interests of the profession or group, the professional or group interests must yield to those of the public; but, to the extent that it is possible to do so by statute or regulation, conflict should be avoided. Similarly, unnecessary interference with self-government should be avoided. It would be folly to ignore or minimize the importance of pride in a profession. Indeed, it is in the highest public interest that there should be professional pride in the provision of such essential services. At the same time, society can no longer afford to tolerate a total abdication by government of the right to guide, direct and, in some areas, become directly involved in the affairs of the professions. The absence of any such guidance, direction and involvement can be blamed for the fact that there has been an absence of planning in a meaningful way for the new and increased role which the members of the various professions and occupational groups are expected to play in modern society. The present problems of manpower and lack of complete harmony with relation to sister professions in an era of increasing teamwork in health care are but two illustrations of the effect of the abdication referred to. Another is the professionally oriented interpretation that the professions have given to the concept of unprofessional conduct to the possible prejudice of the public interest, as shown throughout this Report.

Two examples of this interpretation will suffice for the moment. The freedom of the practitioner to speak his mind on matters of health, subject, of course, to the limitations of the law of defamation, is curtailed by reason of contemporary

professional ethics. For example, a warning notice issued by the Council of the College of Physicians and Surgeons of Ontario in 1969 reads, in part, as follows:

> Any member of the College who is appearing on or participating in TV, Radio and Press Programmes having to do with medical matters shall observe the following:
>
> (1) Conform to the relevant provision of the Code of Ethics of the College of Physicians and Surgeons of Ontario which reads as follows:
>
> Communications to the Laity on Medical Subjects
>
> "All opinions on medical subjects which are communicated to the laity by any medium, whether it be a public meeting, the lay press, radio or television should be presented as from some organized and recognized medical society or association and not from an individual physician. Such opinions should represent what is the generally accepted opinion of the medical profession.
>
> When an official body of organized medicine finds it necessary to ask a medical practitioner to make a statement for the public and decides that the circumstances make it necessary that his name be attached to it, the medical practitioner shall be absolved from criticism in so doing. A physician acting in a public capacity, e.g. a Health Officer, may issue to the public warnings or notices regarding public health matters under his own name.
>
> Radio Broadcasting
>
> It is legitimate and even desirable that topics relating both to medical science and policy and to public health and welfare should be discussed by physicians who can speak with authority on the questions at issue. In any medium of discussion, but especially in radio broadcasting because of its vast range, it is essential that the physician who takes part should avoid methods which tend to his personal professional advantage. Not only should he personally observe this rule, but he should take care that the announcer in introducing him makes no laudatory comments and no unnecessary display of the physician's medical qualifications and appointments. There is a special claim that physicians of established position and authority should observe these conditions, for their example must necessarily influence the action of their less recognized colleagues. These remarks apply particularly to practising physicians. A physician serving in a public capacity is in a different position but even he should see to it that it is his office, rather than himself, that is exalted."
>
> (2) Shall receive the approval of either his branch of the Canadian Medical Association, Ontario Division; or receive the approval of the head of a department in a faculty of medicine with which he is associated; or the head of the department in a university hospital.
>
> (3) The decision as to whether or not the participant shall remain anonymous shall be decided by the same authority indicated above.

Membership in the dental profession also involves a diminution in the civil rights of the practitioner in the area of free speech. In 1966 a dentist was charged before the Discipline Committee of the Royal College of Dental Surgeons of Ontario with improper conduct in a professional respect in that in a radio broadcast he

made defamatory statements with respect to the professional conduct of other members of the dental profession by saying:

> Fluoridation is a red herring. From what I have seen of patients' mouths, I would say dentists couldn't care less about saving teeth. They want to put up a nice front to make themselves look good.

A further allegation against him was to the effect that in another radio broadcast he made a statement with respect to another dentist that the latter had stated to City Council that the dental condition of the people of that city was deplorable and that in making that statement the other dentist was describing the work of the dental profession in that community and that he had further alleged that dentists as a profession were responsible for the situation through neglect of their professional responsibilities. If the accused dentist had in fact made such statements and if they were untrue, he exposed himself to liability for damages for libel in respect of the other dentist but not in respect of the first broadcast, since our law does not recognize a cause of action for libel against a group. It does not appear that the jurisdiction of the civil courts was invoked. But part of the punishment imposed on the accused dentist included the giving of a written undertaking that he would not thereafter make or participate in the making of any statements derogatory (regardless, it would appear, of the truth of such statements) to any licensed members of the Royal College of Dental Surgeons of Ontario, or to any group therein, or to the dental profession as a whole provided, however, that he was not precluded by the undertaking from 1) testifying as a witness at any hearing or proceedings or giving an accurate statement in restrained language for the purpose of any proposed or intended hearing or proceeding, or 2) reporting any action of any dentist or group of dentists to the governing body of the profession, or 3) taking part in any discussion in respect to dental matters at any regularly constituted meeting of the dental profession, or 4) answering accurately and in restrained language any attack made against him, or 5) advising patients in such manner as he deemed to be necessary for their dental health, or 6) contributing in restrained language and devoid of inaccuracy to any publication, dental or otherwise. We do not believe that it is in the public interest to impose restraints not generally imposed by the law of the land on all other citizens, on the freedom of a practitioner to inform the public of his opinions, or to require as a condition of membership in a profession that an individual forego freedoms enjoyed by all other members of society.[1]

While, to succeed, modern regulation must take cognizance of the historical development of the professions or run the risk of destroying important values, the past must not remain the principal concern of those responsible for the provision of health care in the second half of the twentieth century. Just as with education, when we turn our minds to the question of the regulation of the healing arts, we must qualify our consideration of the problems which regulation presents by

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[1]See also J. W. Grove, *Organized Medicine in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1969, p. 173.

the answer to the question: regulation for what end? It is plain that whoever seeks to regulate a service industry must start from an understanding of the way in which the services are performed. Measures appropriate for the regulation of a profession which society has played a small part in creating, which practises in a fractionalized industry in which the ratio of professional to client in the performance of the service is 1:1, where a member of the profession can know enough of all aspects of his art or science to perform adequately, and in which the only method of compensation is fee for services to an unsophisticated clientele may be inappropriate for professions and occupational groups in an integrated industry where treatment of patients is characterized by teamwork in acknowledgement of the explosion of scientific knowledge, where there is a trend towards a combination of method of remuneration by salary and fee for services, where, indeed, most members of a particular team are salaried, where the consumer is more knowledgeable than ever before in history, and where much of the practice is carried on neither in the patient's home nor in the practitioner's office. The trend, too, to public financing of the education and training of the practitioners and to the acceptance of public or state responsibility for health care, not merely public health care, must also form bases on which regulation is designed. We must, in other words, predicate a sound regulatory system on an educated estimate of the direction in which the health industry will be advancing in the immediate future.

As to the historical development of professional regulation, the pattern in North America, as opposed, for example, to Great Britain, has been the conferring on professions of something in the nature of monopolies to perform their healing services through the medium of licensing. In other areas of the economy, licensing of trades and occupations came about by pressures on the legislatures to eradicate abuses that unrestricted practice gave birth to. The licensing of the by-and-large self-governing professions and occupations, on the other hand, came about as a result of pressures on legislatures on the part of those already in those professions or occupations, professing, it is true, that licensing was necessary to protect the public against incompetent practitioners. The preamble of the "Act to Licence Practitioners in Physic and Surgery Throughout this Province",[2] for example, begins: "Whereas many inconveniences have arisen to His Majesty's subjects in this Province, from unskillful persons practising Physic and Surgery therein. . . ." It is anomalous that, although the target of licensing was said to be incompetence, one of the weakest threads in the fabric of the regulation of those who proved competent enough to get admitted to practice has been the inability to eliminate adequately incompetency appearing after the point of admission to the profession.

The problems of licensing require some consideration of the argument of those who oppose licensing by the state on the grounds that licensing is a factor which makes for imperfect competition in the market for health services. The abolition of licensing, removing, as these persons see it, one of the most significant con-

[2](1815) 55. Geo. III, c. 9 (Upper Canada).

ditions creating imperfect competition, would make for the optimum conditions under which supply would, by reasons of market prices, meet demand and, at the same time, assisted by state-sponsored certification, would operate as a sort of quality control. Allied to this philosophy is the school of thought that holds that licensing is an unnecessary and unreasonable interference with the freedom of the individual on the part of an increasingly paternalistic state. The individual, it is argued, unless suffering from one of a small number of contagious diseases which if not treated properly would affect other members of society, should be free to attend the practitioner of his choice, whether he be a physician or a magician. "The idea that the individual knows what is best for himself," say members of this school, "has given way before the concept that it is society which can best judge."[3] This argument, like that relating to licensing as a force making for imperfect competition, leads to the conclusion that the interests of individual freedom dictate that monopoly of practice on the part of certain professions, particularly, of course, the medical profession, should be removed. The Committee is persuaded that the economic arguments in favour of the abolition of licensing are unconvincing. While licensing of all occupational groups in the health field may not be necessary, it is necessary — as a quality control — at least in the senior professions which are now licensed. Furthermore, the Committee is not persuaded that the public today is so sophisticated that all members of the public are entitled to be presumed to be capable of selecting the practitioner to whom they should resort for health care or that it is an undue invasion on the part of society to prevent an individual from being attended, by his choice, by a practitioner objectively not equipped to deal with the particular problem but who, subjectively, the individual feels is the best person to treat him. In an ideal world, we would favour absolute freedom of choice on the part of the consumer. But we do not live in an ideal world, and, for some considerable period of time now, society has placed, and we accept its right to place, impediments in the way of absolute freedom of choice in health matters. Thus we have mandatory provisions requiring quarantine for certain contagious diseases, pasteurization of milk, vaccination of children, and fluoridation of water supplies. Even in the realm of private (as distinguished from public) health matters, our law requires that, no matter what the belief of a parent, a child in need of medical services (need being determined not subjectively by the parent but objectively by society, i.e., in reality on the basis of medical opinion) *must* be given medical care. We have, then, as a society, already decided that there are some matters of health — and an ever-increasing number of matters — that should not be left to individual decision-making, a recognition, it may reasonably be argued, that the average citizen is incapable of making a knowledgeable judgment. The Committee's conclusion is that where factors for and against permitting the consumer to make the decision as to his health care are equally balanced, the scale ought to be tipped in favour of freedom of choice. But the qualification is an important one and leads to the conclusion

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[3]T. G. Moore, "The Purpose of Licensing", (1961) 4, *Journal of Law and Economics*, 93, at p. 93 and see the discussion at p. 106.

that the arguments for "open practice" or for the total abolition of the monopoly of medical practice by persons licensed under the Medical Act must be rejected.

The moment one advocates mandatory licensure[4] of a profession, there is raised the question of defining the practice that is licensed or, to put it another way, of describing the right to practise that is, by licensure, conferred exclusively on those licensed. This has proven to be an extremely vexing question in the past, and, in view of the new patterns of health care that are emerging, will continue to be a difficult problem. The heart of the question is, of course, the medical profession. It was urged on us by the College of Physicians and Surgeons of Ontario that the practice which by the Medical Act is forbidden to any person who is not "registered" pursuant to the Act should be defined. The precise definition which we were asked to recommend will be cited below, but for the moment it will suffice to say that it is so broad that it would effectively prevent anyone but a person licensed by the College to engage in a healing art. At the moment, however, and since 1925, the Medical Act contains and has contained no definition of the scope of practice of those registered under the Act. Notwithstanding the absence of any definition, section 51 of the Act contains the following prohibition:

> No person not registered shall practise medicine, surgery or midwifery for hire, gain or hope of reward, and, if any person not registered pursuant to this Act, for hire, gain or hope of reward, practises or professes to practise medicine, surgery or midwifery, or advertises to give advice in medicine, surgery or midwifery, he is guilty of an offence and on summary conviction is liable for the first offence to a fine of not less than $50 and not more than $500, for the second offence to a fine of not less than $200 and not more than $1,000, and for any subsequent offence to a fine of $1,000 and not more than six months' imprisonment.[5]

It is, of course, understandable that the College of Physicians and Surgeons, to whom is entrusted the enforcement of the Medical Act, including the prosecution of an alleged contravention of section 51, should be unhappy about the absence of a clear meaning of the prohibition. In Ontario at least three kinds of problems have been encountered in this connection. The first two arose out of the semantic difficulties of the language employed in section 51 of the Medical Act itself and the third related to the scope-of-practice language used in another regulatory act concerning another profession or occupational group in the health field — the Chiropody Act. Where the Legislature remains silent as to the interpretation of statutory language it must fall to the courts to give some meaning to

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[4]For purposes of clarification, it should be pointed out that by licensing we mean the conferring on a particular group the exclusive state-granted right to practise. Practice by any person on whom such right has not been granted is prohibited and made a punishable offence. This is to be contrasted with certification by which state endorsation of competence but not as exclusive right to practise is conferred on practitioners meeting certain qualifications. Under this scheme practice by an uncertified person is not prohibited and, of course, is not a punishable offence.

[5]R.S.O. 1960, c. 234, s. 51 as replaced by 1962-1963, c. 80, s. 3.

the language of the legislative draftsman, where a dispute over such meaning arises. Thus, at an early stage of the enforcement of the Medical Act it was judicially determined that the practice of medicine involved the use of drugs, with the result that if an unregistered practitioner of a healing art performed his services without the use of drugs, he did not contravene the prohibition now contained in section 51. Though this is not the present state of the law, it illustrates the problem of the absence of a legislative definition. It was also decided that there is a connotation of repetition of conduct in the word "practise", so that a person who performed an act which, if performed on more than one occasion — that is, with some regularity — would clearly be practising medicine or surgery, but performed it on an isolated occasion only — even though for gain or reward — did not commit an offence under section 51. Whether this is good law is one thing, but law, when all is said and done, is for the layman, and it does not accord with the layman's commonsense conception to say that a man who, for compensation, anaesthetizes a person suffering from appendicitis and surgically removes his appendix has not practised surgery until he does it for the second time. A third illustration of the enforcement problems that arise when the scope of practice of the medical profession is not defined demonstrates the chaos that a student of healing arts legislation finds when he sees that the various legislative enactments were brought into existence as discrete pieces of statutory law rather than as part of a rational and planned program and at the same time sees the need for flexibility in such a program. In the absence of an orderly program, the courts again (and the courts may not be the institution best equipped to deal with these matters) will be called upon to fill the breach and attempt to supply some rationality. It should occasion no surprise, therefore, that the Chiropody Act, which regulates a relatively junior but increasingly important occupational group and which, on the one hand, purports to prohibit resort to certain medical or surgical procedures — namely, the use of anaesthetic other than a topical anaesthetic — and, in the same breath, permits the practitioner to treat a foot condition in a way which would, in the absence of a local anaesthetic, be unspeakably painful, should be interpreted by the courts as not requiring the practitioner to restrict himself to the use of a topical anaesthetic.[6]

A final illustration of chaos in the existing legislative regulation of the healing arts and of the problem created by the absence of a definition of the practice of medicine relates to what is perhaps the greatest anomaly among the regulated professions or occupational groups — namely, naturopathy. The theory and practice of naturopathy are described elsewhere in this Report,[7] and it is unnecessary for present purposes to do more than remind the reader that the naturopath professes to treat patients suffering from diseases, ailments, defects or disability of the human body by, among other methods, special diet and psychotherapy. It is upon these methods that attention will now be focused. In the briefs to the Committee

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[6]In this connection, the interested reader is referred to the discussion to be found in Chapter 15.

[7]Chapter 22.

and throughout its hearings, no one questioned the right of practitioners of naturopathy to use diets or nutrition and psychotherapy without contravening the provisions of section 51 of the Medical Act, although the efficacy of such methods as employed by naturopaths may have been questioned. On analysis of the relevant legislation, however, one cannot find any statutory authority for naturopaths to resort to the methods in question. Few people would quarrel with the statement that the treatment, for compensation, of a sick patient by special diet and/or psychotherapy would be included in the practice of medicine. The fact that such treatment is included in the practice of medicine does not mean, on the other hand, that a practitioner of another healing art, if permitted by the scope-of-practice provision of the statute regulating his profession or occupational group, may not also employ such treatment without offending against section 51 of the Medical Act. The point is that the statute governing naturopaths is not so permissive. Naturopaths practise in Ontario by virtue of the Drugless Practitioners Act.[8] The scheme of this Act is that the Lieutenant Governor in Council is empowered to appoint a board of directors for classifications of drugless practitioners. One of the classifications in respect of which the Lieutenant Governor has appointed a board of directors is that of the drugless therapist. Section 4 of the Drugless Practitioners Act empowers the Lieutenant Governor in Council to make regulations classifying persons admitted to practice under that Act and for prescribing the systems of treatment that may be followed by *drugless practitioners* of different classes, and section 6(e) empowers the Board of Directors of Drugless Therapy, with the approval of the Lieutenant Governor in Council, to make regulations for classifying persons admitted to practice under the Act and for prescribing the systems of treatment that may be followed by *drugless practitioners* of that class (i.e., drugless therapists). It is, of course, only in respect of *drugless practitioners* of the class of drugless therapists that the Board of Directors is entitled to prescribe systems of treatment that may be followed and *drugless practitioner* has a distinct and restricted meaning under the Drugless Practitioners Act. Section 1(b) of the Drugless Practitioners Act defines "drugless practitioner" as follows:

> . . . "drugless practitioner" means a person who practises or advertises or holds himself out in any way as practising the treatment of any ailment, disease, defect or disability of the human body by *manipulation, adjustment, manual or electro-therapy, or by any similar method.* (Emphasis added.)

It would not be seriously suggested by anyone that a board of directors of any classification of drugless practitioner could, in order to extend the scope of practice of its registrants or, for that matter, for any reason, enlarge the concept of "drugless practitioner" as defined by the Legislature in section 1 (b) of the Drugless Practitioners Act by regulation (a form of delegated legislation) by the exercise of the power to make regulations conferred by section 6 (e) of the Drugless Practitioners Act. Yet, that, it appears, is precisely what it has done. In Regulation 121 under the Drugless Practitioners Act made by the Board of Directors of

[8]R.S.O. 1960, c. 114.

Drugless Therapy, "drugless therapist" is declared to be a classification and provision is made for persons to apply to the Board for registration as drugless therapists. We have been told that approved schools or colleges teach "a complete order of natural therapeutics, embracing the use of nature's agencies, processes and products; and include the application of physiotherapeutical (electrical, mechanical, manual, adjustive, manipulative, orthopaedic (*minor surgery*) procedures; emphasizing the treatment of *prophylactics; nutrition, vitamin-mineral, tissue salts; and psychological phyto-therapeutics* (*psychotherapeutics — remedial psychology*)." (Emphasis added.) If this curriculum is kept in mind, one will not fail to be surprised by the scope of practice which the definition of "drugless therapist" in the regulations purports to confer on the practitioner — given, of course, the restricted interpretation of "drugless practitioner" in the Drugless Practitioners Act. Regulation 121 under the Drugless Practitioners Act contains the following interpretation section:

> 1. In this Regulation,
> (a) "drugless therapist" means any person who practises or advertises or holds himself out in any way as practising the treatment by (sic) diagnosis, including all diagnostic methods, direction, advice, written or otherwise, of any ailment, disease, defect or disability of the human body by methods taught in colleges of drugless therapy or naturopathy and approved by the Board.

By no stretch of the imagination can the subjects taught in approved colleges and italicized above be said to be "manipulation, adjustment, manual or electrothereapy" or "any similar method". The Regulation is, it may be suggested, ultra vires[9] or invalid to the extent that it permits a broader scope of practice than that contemplated by the Drugless Practitioners Act as limited by section 1 (b) of that Act.[10] If this view is right, then naturopaths or drugless therapists who treat ailing patients by diet or psychotherapy are not practising under the protection of the Drugless Practitioners Act and are, one may reasonably argue, violating section 51 of the Medical Act if they are not also "registered" under the Medical Act. What kind of health worker is by the existing law entitled to use psychotherapy is a very great uncertainty, and yet from our hearings it would appear that all sorts of persons in the healing arts from psychiatrists to child care workers are, in fact, using it. Is the practice of psychotherapy the practice of medicine?

There are, on the other hand, many weighty arguments against the inclusion in the Medical Act of a definition of the practice of medicine. One of the chief

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[9]Royal Commission Inquiry into Civil Rights, Province of Ontario, Queen's Printer, Toronto 1968, hereinafter referred to as McRuer Report: "The principle of *ultra vires* always applies to purported regulations. If they have not been authorized by the parent statute they have no effect and are null and void." Report No. 1, Vol. 1, p. 380.

[10]If, in the alternative, the Regulation is not, as has been submitted, invalid, it is nevertheless an excellent example of the soundness, as a general principle, of one of the conclusions in the McRuer Report: "The rule should be that judicial tribunals or administrative tribunals with powers of decision on policy grounds should not be established by regulations. The constitution and scope of the powers of such tribunals are matters that should be considered by the Legislature." Report No. 1, Vol. 1, p. 355.

objections is that to define is, etymologically, to limit or to set down the boundaries of what is being defined. In an era characterized by a faster pace of the application of new and established scientific principles than ever before, it may well be myopic of a legislature to confine a discipline to its practice as it is known at the date of the definition, thus inhibiting the beneficial expansion of the practice as new knowledge and procedures become available. There is the additional problem of restraining the growth of other disciplines in the health field and of the optimum use of different disciplines in the health team. This additional problem has been well described in one of the appendices to the Report of the National Advisory Commission on Health Manpower in the U.S.A. (1967) in these words:

> In general, scope-of-practice issues are the most clouded areas in the legal regulation of health manpower, since they have not been adequately resolved by the licensure statutes or related court decisions.[11]

The authors go on to elucidate the problem in language that bears repeating:

> Even though present statutes may provide a legal definition of the present permissible scope of activities of these professions (allied and auxiliary health personnel), they are not designed to provide an optimal allocation of responsibilities among the allied or auxiliary health professions and occupations. They merely state that if a person meets a specified set of qualifications he may perform any of a specified range of functions. A design for optimal allocation must be developed by viewing the health service professions and occupations as a matrix in which duties and responsibilities should be distributed on the basis of a number of factors. One of these factors, present legal definitions, is not necessarily responsive to present and projected requirements for delivery of medical care and, therefore, should not be overly stressed. We should not restrict our thinking to the present qualifications of the various members of the matrix; rather we should examine the entire manpower component of the health care delivery system with the objective of achieving the most efficient and flexible association possible. This requires that many health functions and tasks be delegated to others. For example, the physician who has had many years of training and experience in diagnosis should not be legally required to perform routine and mechanical tasks not requiring the skill and judgment which are the products of completing undergraduate and graduate medical education. His forte is the ability to make difficult medical decisions based upon years of study and experience; having made such decisions, he should be free to delegate to others the tasks of performing, under his supervision and direction, certain routine diagnostic and therapeutic procedures. The realization that, in difficulty of performance, health care services present a spectrum ranging from the most simple housekeeping duties to the most difficult and sophisticated diagnostic and therapeutic procedures should make it apparent that these services ought to be performed by personnel of varying levels of educational and clinical experience.[12]

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[11]Forgotson et al., *Report of the National Advisory Commission on Health Manpower in the U.S.A.*, Vol. II, Ch. 2, Appendix VII, "Licensure of Other Medical Personnel", pp. 407, 413.

[12]*Ibid.*, p. 412.

Their conclusion points to the need to be forward-looking in approaching a solution to this problem:

> Resolution of the problem of allocating tasks among members of the medical manpower matrix will depend, in large measure, on the present and projected character of the system of delivering medical care.[13]

That the problems of restriction of progress by definition, in Ontario, are not mere fanciful fears can be shown by an allusion to the history of regulation in this province. In September 1915 a Royal Commission was appointed to inquire into and report upon all or any matters relating to the practice of medicine, "medicine" in the context of the terms of reference of the Commission (which, incidentally, show a remarkable resemblance to the terms of reference of the present Committee), clearly including practice of osteopaths, dentists, nurses, opticians, optometrists, chiropractors, Christian Scientists, or "others practising or professing to practise medicine". Submissions were made to the Commissioner, Mr. Justice Hodgins, by the College of Physicians and Surgeons of Ontario which highlighted the problem of keeping out of Ontario unqualified practitioners of various healing arts by the uncertainty as to what constituted the practice of medicine. When he reported in October 1917, the Commissioner recommended a statutory definition of "practice of medicine":

> If they are accepted, then the definition of the 'practice of medicine' may be couched in the words following and subject to such modification as will exclude from it the exercise of the tenets of any religion or any practice not properly within it, such as massage under the direction of a regularly qualified physician, or the fitting of glasses by mechanical means or aid given in an emergency. The term 'practice of medicine' shall mean and include:
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> (1) The use of any science, plan, method, system, or treatment with or without the use of drugs or appliances for diagnosing, alleviating, treating, curing, prescribing or operating for any human disorder, illness, disease, ailment, pain, wound, infirmity, injury, defect or deformity or physical or mental condition.
>
> (2) Diagnosing, alleviating, treating, curing, prescribing or operating for any human disorder, illness, disease, ailment, pain, wound, infirmity, injury, defect or deformity or physical or mental condition, and the holding out, offering or undertaking by any means or method to do any of the foregoing and including midwifery and the administration of anaesthetics.
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> (3) Any manipulative or other kind of physical or mental treatment whatsoever, suggested, prescribed or advised, for body or mind, administered to, operated upon, or intended to be followed by the patient himself or herself, intended or professing immediately or ultimately to benefit the patient, and the holding out, offering or undertaking by any means or method to use the same or to diagnose.
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> Any person who shall habitually use in advertising any title such as M.D., M.B., D.O., D.C., D.O.S., or any title as indicated thereby or as surgeon, doctor, physician, healer, professor, specialist or any other letters, sign or

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[13] *Ibid.*, p. 433.

> appellation having the same or similar import in relation to medicine as defined above, shall be considered prima facie as practising medicine. Those possessing the degree of doctor of dental surgery, or being licentiates of dental surgery, shall not be within the above provision.[14]

An examination of the suggested definition makes apparent how inadequate it is as a description of the reality of medical practice fifty years later. Significantly absent is the concept of preventive medicine; it is highly disease-oriented. Furthermore, the concept of teamwork in the provision of health care involving the sharing of tasks heretofore thought of to be the function of the physician was hardly known at the time of the Report.

In 1923 the Ontario Medical Act was amended to add a definition of the practice of medicine in the following terms:

> 47(a) Every person shall be deemed to practise medicine within the meaning of this Act who holds himself out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, disability or physical condition or who shall either offer or undertake by any means or method to diagnose, treat, operate or prescribe for any human disease, pain, injury, disability or physical condition.

This amendment, of course, immediately raised the question about the course to be followed respecting practitioners of the healing arts other than medical doctors and the solution to the question was found in other provisions of the amending Act, specifying that nothing in the Act applied to or affected commissioned medical officers serving in military hospitals, physicians qualified in other jurisdictions consulting with Ontario physicians, hospital residents, first aid or temporary assistance in emergency, domestic administration of family remedies, persons treating human ailments by prayer or spiritual means as an enjoyment or exercise of religious freedom, the practice of chiropody, the practice of dentistry by a qualified dentist, a person who manufactures or mechanically fits or sells artificial limbs or other appliances, or the practice of optometry by a licensed optometrist. Even with this unwieldy list of exceptions, there remained to be dealt with those persons in the province who were practising osteopathy, chiropractic and other forms of drugless healing. An even more awkward provision was inserted in the amending Act to the effect that anyone who was on January 1, 1923 practising as an osteopath, chiropractor or drugless healer could, on filing certain information with the Provincial Secretary, escape any penalty under the Medical Act for the practice of medicine, as long as he continued to practise according to the method named by him in the information which he had filed. Still unresolved was the matter of future recruits to these "non-medical" healing arts and the amending Act empowered the Lieutenant Governor in Council to make regulations for the admission to the *practice of medicine* of persons professing any system of healing and prescribing the qualifications to be required of

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[14] *Report on Medical Education in Ontario, 1917* (The Hon. Mr. Justice Hodgins, Commissioner), King's Printer, Toronto, 1918, p. 66.

such persons, which regulations were not to come into force or take effect until they had been laid before the Assembly and approved by resolution of the Assembly.

A quick glance is all that is necessary to be able to see that the amending legislation created more problems than it solved. Apart from the unsatisfactory and static nature of the concept of medicine which was implicit in the legislative definition of the practice of medicine, it gave rise to a host of questions of a semantic kind in referring to the non-physician practitioners of the healing arts as practising medicine, and it made for a very unwieldy statutory scheme of regulation. It involved the governing body of the medical profession in the affairs of other sorts of health personnel, and although an attempt was made to minimize the enforcement problems thus created by imposing on the Attorney General the duty of prosecuting for offences against the Medical Act, the result was hardly a model of progressive regulation. It was not surprising, then, that only two years later, in 1925, the experiment was abandoned and, along with the enactment of the Drugless Practitioners Act, by 1925 the Medical Act was again amended to remove the definition of the practice of medicine. Thus the situation has remained to the present day.

In its submission to the Committee, the College of Physicians and Surgeons of Ontario proposed that the Medical Act should be amended to include again a definition of the practice of medicine. The precise proposal was that the Ontario Act should contain a definition similar to that found in section 71 of the Medical Act of British Columbia,[15] which reads as follows:

> *Section 71* It is not lawful for any person not registered under this Act or who is suspended from practice to practise or to offer to practise medicine, surgery, or midwifery, and without in any way limiting the generality of the foregoing, a person shall be deemed to practise medicine within the meaning of this Act who,
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> (a) by advertisement, sign or statement of any kind, written or verbal, alleges or implies that he is, or holds himself out as being, qualified, able, or willing to diagnose, prescribe for, prevent, or treat any human disease, ailment, deformity, defect, or injury, or to examine or advise upon the physical or mental condition of any person; or
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> (b) diagnoses, or offers to diagnose, any human disease, ailment, deformity, defect, or injury, or who examines or advises upon, or offers to examine or advise upon, the physical or mental condition of any person; or
>
> (c) prescribes or administers any drug, serum, medicine, or any substance or remedy for the cure, treatment, or prevention of any human disease, ailment, deformity, defect, or injury; or
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> (d) prescribes or administers any treatment or performs any operation or manipulation, or supplies or applies any apparatus or appliance for the cure, treatment, or prevention of any human disease, ailment, deformity, defect, or injury; or

[15] R.S.B.C. 1960, c. 239.

(e) acts as the agent, assistant, or associate of any person, firm, or corporation in the practice of medicine as hereinbefore set out.

It will be seen that the language of such a definition is still disease-oriented and confines the meaning of the practice of medicine to what it is now understood to consist of, if indeed (as is probably more true) it is not backward-looking and ignores modern developments in the practice. In any event, it is certainly not forward-looking, because it fails to take into account the role of the paramedical personnel. Finally, if, as the College conceded, there would have to be an exemption from the prohibition against practising medicine in favour of those professions and groups who are, by other legislation, permitted to practise their several forms of healing arts, it is difficult to see what the inclusion of the definition would accomplish in the long run. In fact, as presently suggested, the provision would appear to inhibit the rational allocation of tasks among those workers acknowledged by the medical profession to be allied and auxiliary health personnel. On balance, the Committee has concluded that it would not be in the best interests of the public and of workers in the health field to recommend that there should be a definition in the Medical Act of the practice of medicine. It is of the view that there is much truth to be found in Samuel Butler's statement that, "Definitions are a kind of scratching and generally leave a sore place more so than it was before."

On the other hand, the Committee has found some justification in the criticism of some of the interpretations place on the statutory language by courts called upon to determine whether an offence has been committed under the Medical Act. It must be remembered that on such an occasion an accused person is on trial and stands to lose property or even liberty if convicted, and that at times like this courts have a propensity, which is not to be condemned, to construe statutory language strictly and to accord the accused the benefit of a reasonable doubt. To compensate for this propensity and to obviate some of the problems of proof that arise in a prosecution under the Medical Act, the Committee proposes that certain changes be made.

Recommendations:

308 That the Medical Act be amended to state clearly that an act which if done with regularity, would amount to the practice of medicine, surgery or midwifery, should be deemed to be the practice of medicine, surgery or midwifery notwithstanding that it was done, or was shown to have been done, on an isolated occasion only.

309 That the obligation to police the prohibition against such practice by persons not registered under the Medical Act ought to be removed from the College of Physicians and Surgeons of Ontario and transferred to the Crown Attorney for the county in which the offence is alleged to have been committed; similar changes should be made in respect of prosecutions for unauthorized practice under the Dentistry Act, the Optometry Act and the Pharmacy Act.

310 That the fact that the practice was for hire, gain or hope of reward should be eliminated as a constituent element of the offence created by section 51 of the Medical Act.

311 That the prohibition against the practice of medicine by any person not registered under the Medical Act should not extend to, and it should be expressly provided that it does not extend to, family care of the sick or family health care, persons performing acts under the authority of other statutes and persons engaging in acts of psychotherapy.

The reason for the first exception of Recommendation 311 is Recommendation 310 that payment be eliminated as an element of the offence created by section 51. The reason for the second exception is the desire to minimize jurisdictional disputes and needs no elaboration; and the reason for the third exception is to be found in our view that we do not regard psychotherapy as a matter within the exclusive competence of physicians or health workers whose scope of practice is necessarily defined by statute.

Regulatory Bodies

The historical development of the regulatory bodies has been described in Chapter 3, and for a fuller treatment of the subject, the interested reader is referred to the study made for the Committee, and published in a separate volume, by Elizabeth MacNab.[16] It is in large part because of the history and traditions of the senior professions and our concern that their dignity and pride should not be impaired that we have refrained from recommending the abolition of the principle of election to the governing bodies of the senior professions. If we could start at the beginning we would be inclined to propose a system in which the members were appointed rather than elected by the members of the profession. We have indicated, and shall again have occasion to emphasize, that it is our view that the purpose for which licensing powers are given to a professional body is the protection of the public against incompetent and unscrupulous practitioners. The advancement of the economic interests, prestige and status of the practitioner is not the business of the statutory regulatory body whose duty is to the public. For such a body to take on functions that are intended to advance the interests of the practitioners would be to involve itself in a possible position of conflict of interest. As will appear shortly, the history of the regulatory bodies in Ontario abounds in decisions, policies and regulations of a truly or apparently restrictive-practice nature. Our examination of the practices of the professions discloses an inclination on the part of the statutory governing body to see itself as the defender of the interests of its members and we believe that this is due in large measure to the fact that their members are elected by the practitioners. It is perhaps not unnatural that one who is elected to a position of prestige in his profession should

[16]Elizabeth MacNab, *A Legal History of Health Professions in Ontario,* Committee on the Healing Arts, Queen's Printer, Toronto, 1970.

see himself as having some obligation to his constituency. It is our belief that the interests of the profession are the province of the voluntary associations and all legislative measures should be aimed at underlining the duty of the statutory regulatory body to the public.

We do not think, however, that the abolition of the election system for the senior professions could be accomplished in the foreseeable future without doing incalculable harm to the dignity or self-confidence of the members of the profession, which would be felt in the manner in which their services are performed. Instead we think everything should be undertaken short of abolition of election, which will bring home to the governing bodies and their members a proper realization of the true relationship between a governing body and the public on the one hand and a governing body and the practitioners on the other. However, we believe that, except for very convincing reasons, the principle of election should not be extended to occupational groups beyond the senior professions as a general rule.

The proper appreciation of the true role of the licensing or regulating body is of such fundamental concern to the Committee that we are prepared to risk the impatience of the reader in our emphasis on it. Our investigations have made it clear to us that the primacy of the licensing or regulating body's duty to the public has not always been understood by the body and its practitioners or, if understood, not always acted upon. It is not true, in our opinion, that what is good for a profession is necessarily good for the country. Our survey of the entire question leads us to believe that even our courts (composed, of course, of professionals) have not always seen the validity of this point. Consider, for example, the following statement made by a judge of the Supreme Court of Ontario in a disciplinary case involving a member of the legal profession:

> . . . I know that every year thousands of dollars worth of business is taken from the lawyers by real estate agents, notaries public, insurance agents and others that should be done by solicitors in the public interest.[17]

A more recent statement in the Court of Appeal for Ontario, in a prosecution against an alleged unqualified person for a violation of the Solicitors Act, also is illuminating:

> One must not lose sight of the purpose of the legislation. It is twofold. It is to protect members of the legal profession who have been admitted, enrolled and duly qualified as solicitors against wrongful infringement by others of the right to practise their profession. It is also for the protection of the public. . . .[18]

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[17]Re the Solicitors Act; Re Hood [1942] O.R. 611; 78 C.C.C. 308; [1942] 4 D.L.R. 505 at pp. 615-616 (O.R.).

[18]Laidlaw, J. A. in Regina ex rel: Smith v. Mitchell [1952] O.R. 896; 104 C.C.C. 247; [1953] 1 D.L.R. 700; affirming [1952] O.W.N. 248; 102 C.C.C. 307 at p. 903 (O.R.)

Our view of the role of the regulatory bodies is, of course, not new. This is illustrated by an extract from the oral presentations to the Hodgins Commission[19] by H. S. Osler, K.C., counsel for the College of Physicians and Surgeons of Ontario on November 29, 1915, whose sound submission bears repeating:

> Now it seems to me that it is absolutely necessary, at the outset of this inquiry, to consider what has been the policy of the legislature in passing this legislation. Is it to create and protect a monopoly, a close corporation having certain monopolistic rights and privileges; or is it to protect the public against imposition and incompetence on the part of those professing to exercise the art of healing and seeking to make a livelihood by so doing?
>
> This appears to me, if I may with respect say so, to be the most important duty imposed upon your Lordship by this Commission, because upon the view you take of the policy and the object of the Act must inevitably depend, as I see it, the view you will take upon the most important perhaps of all the controversies which will arise between the different interest and the parties who may appear before you.
>
> It is unfortunate that one of the judges now sitting upon the Ontario Bench —and the only one, I believe—has taken the view that the Act is solely concerned with the formation of a close corporation with special and monopolistic privileges. That is a view which, on behalf of the medical profession, I absolutely and unqualifiedly repudiate. An individual physician, speaking for himself, and speaking from his own point of view, may very likely use that language in speaking with reference to some local, unlicensed, unauthorized competitor, when his personal interests come into view. It is very difficult for a man who is engaged in practising his profession to avoid that point of view, to avoid using that language, but speaking for the profession at large, speaking officially as representing the College of Physicians and Surgeons, I say that the object of this Act is simply and solely to protect the public against incompetence and fraud, and that all provisions which, in themselves, are directed to or have the result of upholding the dignity and prestige of a profession which is entitled to recognition, are nevertheless created solely in the public interest, and should be so construed and regarded.

We endorse, without reservation the recently expressed view of the Honourable J. C. McRuer in his Report on the Royal Commission Inquiry into Civil Rights:

> The granting of self-government is a delegation of legislative and judicial functions and can only be justified as a safeguard to the public interest. The power is not conferred to give or reinforce a professional or occupational status. The relevant question is not, do the practitioners of this occupation desire the power of self-government?", but "is self-government necessary for the protection of the public?" No right of self-government should be claimed merely because the term "profession" has been attached to the occupation. The power of self-government should not be extended beyond the present limitations, unless it is clearly established that the public interest demands it.
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> In a statement published in 1966 of the functions, procedure and disciplinary jurisdiction of the General Medical Council of England, the purpose of

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[19]Transcript of Proceedings taken before the Royal Commission on Medical Education in Ontario (The Hon. Mr. Justice Hodgins, Commissioner), November 29, 1915, pp. 475-476.

> the power of self-government is well stated in words that should apply to every self-governing body: "The general duty of the Council is to protect the public, in particular by supervising and improving medical education . . . The Council is not an association or union for protecting professional interests. . . .[20]

Analysis of Existing Shortcomings in Regulation

Before considering our proposals for a rational and more coordinated system of regulation, an understanding of the inadequacy of the present scheme is necessary. In order that no surprise be occasioned by any apparent departures from the principle which we have adopted on the issue of self-regulation as opposed to public regulation, that the maximum amount of self-regulation consistent with the public good is to be recommended, we should make clear the confusion, inconsistencies and outright nonsense that has resulted from the separate treatment of the various professions and occupational groups as though they were distinct entities in unrelated industries.

Reference has already been made to the way in which the naturopaths or drugless therapists have apparently extended their scope of practice by making regulations which have been approved by the Lieutenant Governor but which are beyond their competence to make. Another example of inconsistent and ill-reasoned regulation relates to the grounds on which a right to practise may be suspended or revoked. Under the Medical Act[21] a practitioner is liable to have his name erased from the Register if he has been convicted in Canada of an indictable offence or elsewhere of an offence which, if committed in Canada, would be an indictable offence. This is sound in part. But it is not sound that every indictable offence should be considered justification for erasure. The offence should relate to the competence of the practitioner to practise. It does not seem to us, for example, that conviction for dangerous driving, an indictable offence, should automatically jeopardize the right to practise. By way of comparison reference may be made to the regulation of dental hygienist under Regulation 74 of the Dentistry Act[22] which empowers the Board of Directors of the Royal College of Dental Surgeons of Ontario[23] to suspend the registration of a dental hygienist and remove her name from the Register if she "has been convicted of a crime that affects her fitness to practise". In principle, this seems to be a more reasonable provision than conviction of any indictable offence, although even this provision is not entirely well conceived. The use of the word "crime" as opposed to "offence" is open to the criticism that by judicial interpretation "crime" may be restricted to offences created by the Parliament of Canada, as opposed to the Legislature of Ontario, under its exclusive power to legislate in respect of criminal law. Consider, further-

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[20]McRuer Report, *op. cit.*, Report No. 1, Vol. 3, p. 1162.

[21]R.S.O. 1960, c. 80, s. 1.

[22]R.S.O. 1960, c. 91, 26(b).

[23]The Committee will comment elsewhere on the propriety of empowering the Board to regulate dental hygienists (pp. 57-58).

more, section 24 of the Dentistry Act, this time with reference to dentists, which provides for discipline where a member has been convicted of an indictable offence in Canada or elsewhere, the conviction remaining unreversed with the proviso that there should be no exercise of the power to discipline where the conviction is for a political offence or for an offence which although indictable, ought not, from its nature or from the circumstances in which it was committed, to disqualify the person from practising dentistry. Even apart from its vagueness and the uncertainty resulting from the use of language such as "ought not, from its nature or from the circumstances in which it was committed", the provision is hard to defend. It will be recalled that the Medical Act provided for discipline in the case of conviction elsewhere than in Canada of an offence which, if committed in Canada, would be an indictable offence. In many jurisdictions of the world, including common-law jurisdictions the distinction between summary conviction offences and indictable offences does not exist. One often finds a distinction between felonies and misdemeanours, classifications of offences which are not necessarily coextensive with summary conviction and indictable offences. A practitioner may have committed a very serious offence outside Canada which should justify disciplinary action but which is not an indictable offence. In any event, apart from the severity of punishment the principal distinction between summary conviction and indictable offence relates to the form of trial and hierarchy of appellate courts. It affords no reasonable basis for automatic disciplinary action.

To take yet another example, we return to the wonderland of regulation of drugless practitioners and particularly to "drugless therapists", a designation which surely is confusing and ought never to have been authorized. The scheme of the legislation, the Drugless Practitioners Act, is that the Lieutenant Governor in Council appoints a board of directors for one or more classifications of drugless practitioners. Under the scheme a board of directors has been appointed for the classification of drugless therapist. This body, the Board of Directors of Drugless Therapy has power, with the approval of the Lieutenant Governor in Council to make regulations of various kinds. Pursuant to that power, and with the necessary approval, the Board has made regulations.[24] We have seen that in this regulation, "drugless therapist" has been defined to mean a person who practises a treatment by methods taught in schools approved by "the Board". Nowhere in the regulations is the "Board" defined, but what must be intended, surely, is the Board of Directors of Drugless Therapy. There are, of course, other classifications of drugless practitioners—namely, chiropractors, osteopaths, physiotherapists and masseurs—and each has its own Board of Directors to regulate its own practitioners. With the creation of each board the predecessor "umbrella" Board of Regents for drugless practitioners of all classifications ceased to regulate the practitioners of the classifications for which a separate Board was created as each was created and, ultimately, ceased to function. Returning now to Regulation 121, made by the Board of Directors of Drugless Therapy, section 7 purports to require not merely

[24]R.R.O. 1960, Regulation 121.

every drugless therapist, the classification over which this Board has jurisdiction, but "every drugless practitioner" to register with the Board, which, as already indicated, must mean the Board of Directors of Drugless Therapy. Similarly, section 29(1) of the Regulation purports to provide that the "certificate of registration of any *drugless* practitioner (i.e. chiropractor, osteopath, drugless therapist, physiotherapist, and masseur) may after due inquiry by the Board (of Directors of *Drugless Therapy,* clearly) be either suspended or cancelled for incompetence misconduct, or breach of this Regulation". Other provisions of Regulation 121 (sections 8, 30, 31 and 32) also purport to give the Board of Directors of Drugless Therapy jurisdiction over *all* drugless practitioners. The legislative machinery can only be described as sloppy and, in our view, this sloppiness results from a failure to supervise or recognize any responsibility for supervision of the legislation respecting health professions and occupations. This state of confusion is to be explained largely by piecemeal growth of regulation of the different classifications of drugless practitioners. It is difficult to find in the existing legislation—namely, the Drugless Practitioners Act and the Regulations respecting the classification "drugless therapist"—authority of the practice of issuing two types of licence, one for drugless therapy and another for naturopathy; and this, again, is likely the result of the absence of careful supervision in drafting the legislation for drugless practitioners.

The form and substance of Regulation 121 under the Drugless Practitioners Act came into existence literally by a process of subtraction. In 1944 Regulation 214 under the Drugless Practitioners Act was drafted, approved and filed. This Regulation governed the practice of chiropractic, osteopathy, massage, physiotherapy and drugless therapy, and was administered by the Board of Regents, under the Drugless Practitioners Act. In 1950 when the Board of Regents was replaced by separate boards, the new boards were given their own regulations, except for the Board of Directors of Drugless Therapy. The latter Board's regulations consisted of Regulation 214/44, amended by the process of subtraction and deletion of all material dealing with a discipline other than drugless therapy. This, in part, explains why sections 7, 8, 10 and 11 purport to deal with a "drugless practitioner". The so-called "draftsmen" of Regulation 121 neglected to take the trouble of changing the terminology of these sections from the general to the particular—i.e. from "drugless practitioner" to "drugless therapist".

That the unsystematic method of supervising or administering health legislation, and particularly amendments to the legislation, is not merely a matter of ancient history can be seen by an examination of some fairly recent legislative activity. Section 1 of the Medical Amendment Act 1968 chapter 69 amends section 41(1)(a) of the Medical Act[25] providing for an appeal from the discipline committee of the College of Physicians and Surgeons of Ontario to a judge of the Supreme Court of Ontario with a further right of appeal to the Court of Appeal. It was formerly to the Court of Appeal that an appeal lay after an appeal to the

[25]R.S.O. 1960, c. 234 re-enacted by section 7 of the Medical Amendment Act 1966, c. 85.

Council of the College. The 1966 amendment changed the procedure by providing for an appeal from the Discipline Committee either to the Council or to a judge of the Supreme Court with a further right of appeal to the Court of Appeal in either event. With the 1968 amendment an appeal from the Discipline Committee lies to a judge of the Supreme Court with a further right of appeal to the Court of Appeal. But it would appear that no thought was given to the jurisdiction conferred on the Discipline Committee of the College of Physicians and Surgeons of Ontario by section 51 of the Pharmacy Act,[26] which deals, in part, with excessive prescribing of certain drugs by physicians. Under that provision where the disciplinary body (which, by the way, is given, for this kind of misconduct, the same powers as may be conferred upon a commissioner under the Public Inquiries Act), takes disciplinary action, an appeal lies directly to the Court of Appeal.[27] Surely there is no sound reason why the appeal procedure in respect of discipline of a physician should be different if his misconduct is being dealt with under the jurisdiction conferred on the disciplinary body by the Pharmacy Act rather than the Medical Act. Is it not also less than unsatisfactory that the jurisdiction of the College of Physicians and Surgeons over a physician's prescribing practices should be found in an Act that is primarily concerned with the regulation of pharmacists? Elsewhere we have something to say about the merit of regulating the sale of drugs and poisons in the same statute that regulates the profession of pharmacy.[28]

Another respect in which the absence of governmental surveillance in the interests of the public is noticeable in the legislation is the extent to which restrictive practices have been permitted to be authorized by the regulating body. Our study of the professions has led us to the conclusion that, if left to their own devices, the profession or occupational group tends to seek legislation, make regulations, and adopt rules and practices which are concerned with their self-protection as a guild or which are in their economic interests. Perhaps one of the best examples of this phenomenon is to be found in the evolution of chiropody.

Elsewhere, we have pointed out the lamentable shortage of persons with the requisite skills to care for the large numbers of residents of Ontario suffering from foot problems. The unfortunate non-existence of personnel capable of alleviating the discomforts of so many members of the population, especially in the older age groups, results from a combination of abdication in this area of health on the part of medically trained persons on the one hand and the unilateral increase in the qualifications of chiropodists by chiropodists never contemplated by the legislation on the other hand. A "chiropodist" is defined in the Chiropody Act[29] as a "person other than a duly qualified medical practitioner who practises or holds himself out in any way as practising the treatment of any ailment, disease, defect or disability

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[26]R.S.O. 1960, c. 295, s. 51(6).

[27]*Ibid.*, s. 51(7).

[28]See Chapter 11.

[29]R.S.O. 1960, c. 54.

of the human foot". Our review of the legislative history of the health field satisfies us that it was never the intention of the Legislature in enacting the Chiropody Act to create a profession that required a training period that was almost equivalent to that of a medical doctor. Although, as we have already indicated, the language of the Act is not free from ambiguity, it is reasonably evident that what was intended was a health worker with very limited skills and knowledge. Thus section 4 of the Act provides that nothing in the Act or regulations shall authorize any chiropodist to administer any drug internally or to prescribe any drug for use internally, to administer an anaesthetic other than a substance applied externally to the skin, or to practise medicine, surgery or midwifery, with the proviso that nothing in the Act or the regulations prevents the treatment by a registered chiropodist of morbid conditions of the nails and skin and resulting minor morbid conditions of the subcutaneous tissues of the human foot. Whatever may be the result in a prosecution where the issue is whether a particular treatment of the foot falls within the permissive language of section 4 of the Act or constitutes the practice of medicine or surgery, we think there is sufficient evidence in the language employed of an intention to confine the scope of practice of chiropodists to relatively minor conditions—conditions, that is, the treatment of which does not require the services of one who is as highly trained as a physician or surgeon. To us it seems the height of naiveté to believe that the practice of chiropody as defined in the Act would attract a large number of practitioners if the educational requirement of admission to practice was a course of study involving two pre-chiropody years at university level followed by four professional years in a school of chiropody. Yet such a requirement is precisely what has been developed by reason of the granting of self-government to chiropodists. The function of admitting chiropodists to practice in Ontario has been entrusted to a Board of Regents appointed under the Act. All members appointed to the Board have been chiropodists. The Board is given the power to make regulations prescribing the training and qualifications of persons so to be admitted and of providing for approval of schools, colleges or universities and prescribing educational standards, methods and hours of training and instruction facilities, and other requirements for approved schools, colleges or universities. These regulations require the approval of the Lieutenant Governor in Council, but the essential point is that with the approval of the Lieutenant Governor in Council the Board of Regents has made regulations accrediting only American podiatry colleges, there being no accredited or other schools of chiropody in Canada. The American schools, from which anyone wishing to practise in Ontario must graduate, are equipped to produce podiatrists whose scope of practice is not limited, as that of chiropodists in Ontario, to cases not involving the use of drugs, anaesthetics or surgery, since most U.S. jurisdictions allow podiatrists a much broader scope of practice than Ontario does. The result, of course, has been that Ontario chiropodists must undergo an educational experience that in duration is just as long as a medical student's, and are trained, and consequently are tempted to use their training, to perform tasks that are much more serious and require much more skill than the tasks contemplated by the Chiropody Act. More regrettable is the fact that persons

trained to the level contemplated by the Chiropody Act—as, for example, the United Kingdom-trained chiropodists are—are disqualified from practising in Ontario because the Board has chosen to accredit only those schools which produce podiatrists. The Committee believes that Ontario will never attract as many recruits into chiropody as are needed if, as a condition of being admitted to practice, they must undergo a six-year training period. The professional self-aggrandisement resorted to as a means of enhancing the status of the profession has operated contrary to the public interest and has been a disservice to the people of Ontario.

Regulation and Restrictive Practices

Again we emphasize the importance of the realization of the true nature of the grant of licensing and regulating powers to a self-governing profession. It is a grant by the sovereign legislative authority, representing society, to a licensing body, owing its existence to an Act of the Legislature, to permit it to exercise its powers, conferred for the protection of the public against incompetent or dishonest practitioners. These powers must be exercised by the licensing body as a trustee, not for the practitioner, but for the public. The correct view of the purpose and nature of licensing is to be found in the language of an American physician-lawyer student of the subject in a recent work:

> Let us be quite clear that the essential purpose of such a statement by the body politic is to protect itself in a very special interpersonal relationship. While a medical practice act conveys special status on physicians, status is incidental to its primary purpose. Essentially, its purpose is to provide a means by which society may exercise formal control over persons designated to minister to its ills.[30]

Specific examples of protectionism or restrictive practices abound and some of them will be referred to, but the history of the professions discloses a general tendency which is unmistakable. In the admission to the profession, for example, one finds a traditional general adoption of criteria for membership that are irrelevant. Discrimination on the ground of race, creed and place of origin has not been unknown. Almost universally citizenship or nationality has been a condition of membership. In the area of dental personnel, for example, an applicant for licensure as a dentist, until 1967, and, even today, as a dental hygienist, was required to be a Canadian citizen (in the case of the dental hygienist, a Canadian citizen or British subject or to have an intention to apply for Canadian citizenship). It would be difficult to conceive of an attribute that is less related to competence to care for the dental health of the public than the Canadian citizenship of the practitioner. We are in enthusiastic agreement with the recommendation of the Royal Commission Inquiry into Civil Rights[31] that citizenship should not be a condition precedent to membership in a profession. We are not persuaded, however, of the

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[30]S. Shindell, The Law in Medical Practice, University of Pittsburgh Press, Pittsburgh, 1966, p. 3.

[31]McRuer Report, *op. cit.*, Report No. 1, Vol. 3, p. 1176.

validity of the qualification contained in the Report that a non-British subject should, by reason thereof, be disqualified from holding office. In our view there ought not to be two classes of members, one with full rights and the other partially disfranchised. We think that the fact that the possession of regulation-making powers or, in other words that the governing body exercises a "legislative power" delegated to it by the Legislature, is not a convincing enough reason to disqualify members who are not British subjects from holding office and justify the creation of a "second-class" member. The argument that it is "inconsistent with the exercise of delegated legislative power and judicial power that the power may be exercised by persons who would not ordinarily be qualified to vote or sit as members of the Legislature which delegates the power",[32] is, respectfully, an overly legalistic view of the danger of permitting office holding by non-British subject members of a profession. Furthermore, it should be noticed that the regulation-making power contemplated by the McRuer Report, which we accept, is not a sovereign power in that all regulations—i.e., provisions or "rules which materially affect the public"[33]—require the approval of the Lieutenant Governor in Council[34] before they have the force of law, and, indeed "all matters relating to admission and discipline should be dealt with by regulations made by the Lieutenant Governor in Council".[35] We are of the opinion that these qualifications of rule-making powers are more than a sufficient safeguard, in the context of a proposal of disfranchisement, against the dangers of permitting non-British subjects, who are members of a profession practising in Ontario, to exercise legislative and judicial powers.

Before leaving the subject of this aspect of the McRuer Report, we feel it appropriate at this point to state that our examination of the legislation and regulations pertaining to the professions and occupational groups within our terms of reference had made abundantly clear to us both the wisdom and the necessity of the McRuer Report recommendations respecting the rule-making power of the various governing bodies. We entirely agree that a uniform terminology should be adopted and employed and that the term "regulations" should be reserved for those rules which materially affect the public and, accordingly, should be matters of public record published in the *Ontario Gazette,* and that by-laws should deal only with "housekeeping" matters or matters of administration and domestic affairs such as management of property and meetings of council.[36] By-laws, unlike regulations, need not receive the approval of the Lieutenant Governor in Council before becoming effective and, as recommended, regulations dealing with admission and discipline should be made by the Lieutenant Governor in Council. But it is important to have an objective determination of what is "housekeeping" and what is a matter which materially affects the public. Our inquiry into professional

[32] *Ibid.*, p. 1177.
[33] *Ibid.*, p. 1170.
[34] *Ibid.*, p. 1171.
[35] *Ibid.*, p. 1121, Recommendation 25.
[36] *Ibid.*, Ch. 80.

habits of thought has revealed strong evidence that the necessary objectivity cannot always be expected from the professions. We have had occasion to examine some of the draft legislation proposed by the professions as statutes to be enacted to implement the McRuer recommendations. The best example of what must not be permitted to be enacted is the product of a senior profession that is not within our terms of reference and, while we do not purport to deal with any profession that is not within our purview, we think it incumbent upon us to use the revised draft of a proposed new Law Society Act[37] to illustrate what ought not to be permitted in the healing arts.

In the explanatory notes to the draft Act the statement is made that in the preparation of the revision of the Law Society Act, "most of the applicable recommendations of the McRuer Report with respect to self-governing bodies have been adopted".[38] On the subject with which we are now concerned, there is to be found the following explanatory note:

> Matters of concern to the public are taken out of the rules and made matters for regulations, which are not effective unless approved by the Lieutenant Governor in Council. These regulations come under the Regulations Act and therefore must be filed with the Registrar of Regulations and published in The Ontario Gazette.[39]

While it may be true that, numerically, most of the applicable recommendations of the McRuer Report have been adopted, it is certainly not the case, as will appear, that the most important recommendations have been adopted. Similarly it cannot be said, from any reasonably objective point of view, that matters of concern to the public are taken out of the rules and made matters for regulation. An examination of relevant parts of the proposed sections 50 and 51 make this clear:

> 50. (1) Subject to section 51, Convocation may make rules relating to the affairs of the Society and, without limiting the generality of the foregoing,
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> 19. prescribing the qualifications of persons entitled to be called to the bar and admitted and enrolled as solicitors;
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> 21. prescribing the qualifications of persons entitled to be admitted as members or student members;
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> 23. providing for and governing the admission as members of persons from outside Ontario;
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> 24. respecting legal education, including the establishment and maintenance of a law school;

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[37]As approved by Convocation, April 18, 1969.

[38]Draft of a Proposed New Law Society Act, approved by Convocation, April 18, 1969, The Law Society of Upper Canada, p. 1.

[39]*Ibid.*, p. 3.

25. respecting the Bar Admission Course;

26. defining and governing the employment of student members while under articles;

. . . .

28. providing for and governing post-graduate courses, extension courses, continuing legal education, and legal research;

29. providing for and governing degrees in law;

30. providing for the establishment, operation and dissolution of county and district law associations and respecting grants to such associations;

31. providing for and governing libraries;

32. respecting the reporting and publication of the decisions of the courts;

33. providing for the occasional appearance as counsel in the courts of Ontario and before provincial judges, with the consent of the Treasurer, and of the court or judge, of members of the legal profession from outside Ontario.

. . . .

(2) The rules made under subsection 1 shall be interpreted as if they formed part of this Act.

51. Convocation, subject to the approval of the Lieutenant Governor in Council, may make regulations respecting any matter that is outside the scope of the rule-making powers specified in section 50 and, without limiting the generality of the foregoing,

1. respecting the conduct and discipline of members and student members and the suspension and restoration of their rights and privileges, the cancellation of memberships and student memberships, the resignation of members, and the re-admission of former members and student members;

2. requiring and prescribing the books, records and accounts to be kept by members and providing for the exemption from such requirements of any class of members;

3. requiring and providing for the examination or audit of members' books, records, accounts and transactions and the filing with the Society of reports with respect thereto;

4. authorizing and providing for the preparation, publication and distribution of a code of professional conduct and ethics.[40]

We are at a loss to understand how it could reasonably be maintained that the matters referred to in those paragraphs of the proposed section 50(1) set out above, which, it will be recalled, are, by virtue of subsection 2, to be interpreted as though they formed part of the legislation, related to the affairs of the Society, the licensing authority for lawyers, and were not matters of concern to the public, which the explanatory note indicated had been taken out of the rules and made matters for regulation. Similarly we do not see how a professional body can limit the

[40] *Ibid.*, pp. 17-19.

regulation-making power to matters outside the scope of the rule-making power when the rule-making power includes matters that are the legitimate province of regulations.

While the example comes from the legal profession, it is our conclusion that inability to be objective in discerning the public interest as opposed to professional interest and the assumption that the two interests coincide because the profession is public spirited are common to all professions. The question who may practise a profession is a question for society and not for existing practitioners even though, as a matter of convenience and efficiency, society has in the past delegated the responsibility of assessing competence to the profession. And the inability to see that the determination of qualifications for practice and the education of practitioners are matters in which the public has a strong interest makes it imperative that the decision as to the nature of the regulation or rule (by-law) be made by a person or body capable of exercising objective judgment, and that the public be given a meaningful participation in the government of the professions. We shall return to this last point again.[41]

Recommendation:

312 That, for the purpose of determining whether a matter affects only the governing body of the profession and thus is properly the subject of the rule-making power of that body or affects the public and is thus properly the subject of the regulation-making power, the decision as to the nature of the rule or regulation not be left exclusively to the determination of the governing body of the profession but be reviewed by the Minister of Health with the assistance of his legal advisers.

The conflict between professional interest and public interest is best exhibited by the protectionist devices resorted to by the professions as well as by their almost universal habit of restrictive practices. These are to be found in the senior professions in the healing arts as well as in the other senior professions and the junior occupational groups in the healing arts. Turning briefly to the medical profession we can discern a traditional fear of competition. Today, for example, there is to be found the unfortunate "jurisdictional dispute" between physicians and dentists which takes the form of a controversy as to the proper province of the oral surgeon (a dental specialist) and the plastic surgeon (a medical specialist). With their power of control over hospital privileges, members of the medical profession have placed impediments in the way of making the skills of the oral surgeon as readily available as they should be to the public in the cases of traumatic injury to the jaw and associated areas of the face which are necessarily treated in hospital. But professional jealousies are not new in Ontario. Some thirty-five years ago objections were voiced in the medical profession to the ex officio membership of the Minister of Health on the Council of the College of

[41]See pp. 62-63.

Physicians and Surgeons,[42] and in the same year the press in covering a meeting of the College of Physicians and Surgeons on June 29, 1932 reported that a representative of Victoria University was critical that "too many physicians are being turned out in Canada, with the result that the economic condition of the medical profession is being lowered".[43] At the same meeting which was continued the following day, a debate between specialists and general practitioners occurred, and the public was told, "The general practitioners charged that the specialists were acting out of their self-interest and intended to broaden the scope of the specialities which would only result in distributing medical patronage."[44] Expressions of fear of competition are today rare, and while it is true that the expressions cited are from the days of the Great Depression, the "closed-shop" mentality is very much a part of professional psychology. In medicine its tradition is as old as the organized profession and is enshrined in the Hippocratic oath.[45] The "ethical" proscription of teaching by ophthalmologists in institutions in which optometry is taught,[46] surely a practice that is contrary to the public interest, is entirely consistent with medical ethical traditions. The hostility to outsiders is, however, not confined to non-medical practitioners but extends to the foreign medical graduate.

The Committee has discerned an interesting contrast between the normally rigid attitude towards the foreign-trained practitioner and relative flexibility when the restrictive licensing practices are under the public spotlight. When the public has become aroused the reflex action that it would be unthinkable to license physicians from some parts of the world has changed to an attitude that on humanitarian grounds, for example, practitioners who have fled from a politically oppressive society might be licensed. If the restrictions against foreign practitioners were valid in the first place, the only acceptable criterion being the public interest, we are unable to see why exceptions should be made for refugees from totalitarian countries. The reasonable suspicion which arises in the mind of the public is that the restrictive regulations were dictated more by professional concern than by concern for the safety of the foreign practitioners' potential patients.

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[42]Elizabeth MacNab., *op. cit.*, p. 89.

[43]*Toronto Star*, June 29, 1932.

[44]*Toronto Star*, June 30, 1932.

[45]"To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture; to impart precept, oral instruction, and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician's oath, *but to nobody else.*"

[46]"(b) Members of the Society may formally teach or instruct directly or indirectly, only medical and paramedical personnel.*

*Paramedical personnel being defined as those who have been trained by duly qualified physicians or under their supervision and direction, who work under the supervision and responsibility of physicians and who do not have legal rights (by legislative acts) to have patients of their own."

Article XVII "Ethics" of the Constitution of the Canadian Ophthalmological Society.

One would have thought that in translating public policy into legislation the natural propensity of professional governing bodies to create guild-protecting rules would have been taken into account and safeguards devised to neutralize this tendency of professions. Instead, the absence of a public repository of responsibility to see that professional self-government harmonized at all times with the interests of the public at large permitted the enactment of legislation and subsidiary legislation in the form of regulations or by-laws that were designed to promote restrictive practices. Legislation respecting the dental profession affords a good example. Not only was the dental profession allowed to develop restrictive practices in the regulation of its own numbers but, what is even more objectionable, it was given the right to regulate a subsidiary occupational group, the dental hygienists, and it exercised that right in the interests of, not the regulated, and not the public, but the regulators. Section 12 of the Dentistry Act[47] states:

> The Board has power, subject to the approval of the Lieutenant Governor in Council, to pass by-laws,
>
> (a) providing for the establishment, development, regulation and control of an ancillary body known as dental hygienists;
>
> (b) providing for the delegation to dental hygienists of the performance, under the direct control and supervision of a member of the College, of the services of cleaning and polishing teeth and the giving of instructions and demonstrations in oral hygiene and mouth care;
>
> (c) prescribing other specific dental duties of a minor nature that may be similarly delegated for performance by dental hygienists;
>
> (d) regulating the conditions and prescribing the qualifications for admission to such body;
>
> (e) prescribing the admission and annual fees payable by members of such body;
>
> (f) generally for the defining, regulating and controlling of the practice of dental hygiene.

The opportunity to create and regulate a "para-dental" occupation might have been seized upon to create workers who could have been trained to relieve the dentists from many of the simpler tasks which they now perform. The Committee was not convinced by the spokesmen for dentistry who claimed there were serious enough reasons why it was impractical to create in Ontario a dental worker with the functions and responsibilities of the New Zealand dental nurse and the British dental nurse, categories of dental personnel described elsewhere in this Report.[48] Under the power conferred on the Board of Directors of the Royal College of Dental Surgeons of Ontario, a two-year university course was organized and developed to train girls to perform tasks which, in the opinion of the Committee, require neither two years to master nor university education. Furthermore, the existing functions of the dental hygienist do not require university entrance quali-

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[47]R.S.O. 1960, c. 91.

[48]See Chapter 9.

fications as a condition precedent to admission to the course. In addition, not only did the Board write into the program for the training of dental hygienists the usual but irrelevant requirement that an applicant be a Canadian citizen or have an intention to become a Canadian citizen,[49] but the rather surprising qualification that the applicant be a female person.[50] In the context of the formal (as opposed to working) relationship between dentists and dental hygienists, the public might be forgiven the suspicion that the requirement that dental hygienists be female persons owes its origin to the belief that male dental hygienists might be more difficult to control professionally than female subordinate personnel. Finally, the restriction on the number of dental hygienists who may be employed by a dentist is yet another unsupportable restriction and is particularly suspect as being a device to limit competition among dentists given the unequivocal evidence that the net income of a dental practitioner rises with the employment of assistants. Article XIV of the By-Laws of the Royal College of Dental Surgeons of Ontario, bearing the heading "For the Regulation of the Profession of Dentistry", contains this provision:

> A member may employ one dental hygienist only, registered with the College and licensed for the current year.[51]

Perhaps one of the best examples of regulation in the guild interest at the expense of the public interest is to be found in Article XIV, section 14, which may have the effect of depriving a community that is unable to support a dental specialist full time in his specialty of the services of a dental specialist because he is prohibited from competing with dental general practitioners. The section reads as follows:

> No member of the College shall announce himself to the public or hold himself out to the public as a specialist, or as being specially qualified in any particular branch of dentistry, or limiting his practice to any branch of dentistry, unless he has complied with the additional requirements established by the Board and is the holder of an unrevoked Certification of Qualification as a specialist. The Board is hereby empowered to give such examination as it may deem necessary to determine the qualifications of applicants. Every member of the College receiving a licence to practise as a specialist must, as a condition of qualification, limit his practice to that specialty to the exclusion of general practice. Every such certification of qualification issued by the Board shall be subject to revocation by the Board at any time in case it shall determine in its sole judgment that a candidate who has received his certificate either was not qualified to receive it or has become disqualified since its receipt by failing to limit his practice or otherwise.

In the Committee's view the profession with the most rigid attitude towards foreign graduates has been the dental profession. While we lack the expertise to

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[49]O. Reg. 332/65, s. 7(1) (b).

[50]*Ibid.*, s. 7(1) (a).

[51]Section 10(d).

judge competence of a practitioner, we have reluctantly been driven to the conclusion that some, at least, of the impediments placed in the way of foreign dentists are based not on a concern for the dental health of the population but rather on a less-than-convincing position that Ontario dentists clearly, and by a wide margin, surpass in competence dentists from all other jurisdictions. We have dealt with the problem of foreign-trained dentists elsewhere[52] and, for the moment, content ourselves with a reference to the requirement that a foreign dentist desiring to convince the Royal College of Dental Surgeons of Ontario that he is competent to practise in Ontario is required to find and produce a patient suffering from the proper dental disease as a subject on whom to demonstrate. The number of foreign dentists deterred by such a requirement from ever attempting practical examinations is not known.

In all the circumstances, and quite apart from the principles relating to the proper relationship between the education body and the licensing body which the Committee has enumerated, the Committee regards as totally unacceptable that the Board of Directors of the Royal College of Dental Surgeons, the licensing body, should have representation on the Council of the Faculty of Dentistry of the University of Toronto and particularly that a representative of the Board should sit on the admissions committee of the Faculty.[53] It is important that there should be no fear or suspicion on the part of the public that a professional licensing body should have a voice in the determination of who is admitted to the educational experience provided by the university, even though that experience is also the preparation for the practice of the profession.

Pharmacy, a newer profession than either dentistry or medicine, is an occupation which, by reason of the retail-trade aspect of its practice, has given rise to much debate on the issue whether it is truly a profession. We have made clear in Chapter 11 that we are of the view that it is entitled to be considered as a profession and that, as such, its proper educational centre should continue to be the university. Quite apart from our conclusion, however, if the existence of protectionist behaviour is a criterion upon which it is decided that an occupation is a profession, pharmacists are clearly professionals. And, as in the case of dentistry, their restrictive practices have been accorded legislative sanction. One of the most striking features of the profession to come to the attention of the Committee was the relatively small number of pharmacists in Ontario who were trained outside Ontario. Indeed, until the regulations were recently amended after the Committee, at its hearing with the Ontario College of Pharmacy, questioned its defensibility, section 11 of the regulations,[54] provided that applicants for registration in Ontario who were qualified to practise pharmacy in a jurisdiction other than Ontario should not be registered in excess of one per cent of the registered pharmaceutical chemists

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[52]See Chapter 9.

[53]Royal College of Dental Surgeons of Ontario, Transcript of the Hearings of the Committee on the Healing Arts, April 3, 1967, pp. 1920-1921.

[54]R.R.O. 1960, Reg. 480 as amended by O. Reg. 234/63 and O. Reg. 294/64.

in Ontario in the same year. Still unchanged, however, is the impediment to migration to Ontario of qualified practitioners from elsewhere, even from the other provinces, that is found in the requirement, which, in our view, cannot be defended, that an out-of-province applicant for registration must have resided in Ontario during the six months preceding the application.[55] Those pharmacists who are not deterred entirely from coming to Ontario by this requirement, must either forego practising their profession for six months or work in pharmacy for less than a professional salary.

In the brief of the College, the Committee was impressed with the frankness with which the question of the practice of dispensing by physicians was characterized by the College as one involving both the public interest and professional intrusion. In a system in which every member of the health industry saw his role with relation to the health industry as a whole, and not as a monopoly to practise in a defined area, the concern of a professional should be only with the public interest and not protection of his own profession unless the competition in question came from persons who were a danger to the public. The Committee was not persuaded, and does not believe that pharmacists are persuaded, that a physician who dispenses drugs and pharmaceuticals is a danger to the public.

While we have fastened on the overt restrictive practices of the health professions because of our terms of reference, we think it only fair to them to point out that our studies of professional conduct and habits have shown us that the health professions have a record that is no worse and no better than other professions. The point we wish to emphasize is the inherent conflict in a professional governing body between its relationships to the public and its relationships to its own members. As we have previously suggested, this conflict is exacerbated by the election of members of the governing body by members of the profession. Reference has already been made to the confusion in the statutory language in the Chiropody Act in defining the scope of practice of chiropodists, necessitating, in the final analysis, lengthy litigation to arrive at a judicial interpretation of the legislative intent of the statute in order to resolve what, in another context, would be considered a jurisdictional dispute. With its limited access to social facts, given the adversary system in which it operates, a court, though thoroughly competent in the rules of construction of statutes, may not be the most appropriate body to determine questions of competence of practitioners in the context of the kind of litigation in the Foote case.[56] As will appear later, the courts, on questions of professional ethics and professional misconduct, have deferred to the judgment of the professions concerned. No less an authority than the McRuer Report[57] has expressed this view: "In general, questions of professional or occupational misconduct, incompetence and unethical practices are matters which the leading members of a

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[55]Regulation 480, s. 14(1) (a).

[56]See Chapter 15.

[57]McRuer Report, *op. cit.*, Report No. 1, Vol. 3, p. 1183.

profession or occupation should be best able to judge." Some of the implications of this statement will be explored later, but, at the moment, it is enough to say that, in the discussion above, we have selected for comment only some of the deficiencies in the separate legislative enactments governing the health professions and occupations. There are many more. Those chosen, however, are illustrative of the unevenness of the manner of dealing with them, the degree of chaos in health legislation, and the extent to which there has been inadequate or even merely nominal supervision over and responsibility for the legislation in the public interest, that is, by government. Too much has been left to the professions themselves. To be unduly critical of government, however, would be unjust, because it has been only recently that society as a whole has come to accept that health care for all members of society is a public concern, and the very creation of this Committee is evidence enough of government's realization of the problem. In any event, to apportion blame is unnecessary and would be to ignore the magnitude of the problem relative to the resources that, heretofore, have been committed to the task.

What appears to be clear, however, is that there should be recognized a responsibility to review and rewrite all the legislation, cull out the anachronisms that no longer have relevance to the contemporary health scene such as, for example, the contemplation, in section 14(1) of the Medical Act, of the creation in Ontario of a homoepathic medical college for teaching purposes, propose suitable amendments, and, most important, keep a watchful eye on the legislation and the behaviour of the professions in the future. Our recommendation in this area is, again, in accord with the recommendations of the McRuer Report.[58] We recommend that this obligation properly belongs to the chief law officer of the Crown, namely, the Minister of Justice and Attorney General. We are, of course, now addressing ourselves to the question of legislative supervision. Health policy must certainly remain in the Department of Health, but its translation into legislative action is a legal skill. In stating that the skills necessary for the task that we have in view are those of the lawyer, we mean by a lawyer a person whose primary interest is law as decided by the courts and by legislation, and not merely a member of the bar whose area of expertise is health first and law second. To the objection that the lawyer must be familiar with the problems of the health field, we say we agree and that some expertise in this area can and should be developed in the Attorney General's department, because, as we have indicated, what we are now dealing with is not policy or program but only professional skills.

Recommendation:

313 That responsibility be given to the Minister of Justice and Attorney General to review, and where necessary rewrite, the legislation concerning the healing arts to make it conform with government health policy, and that the Department of Health maintain a constant super-

[58] *Ibid.*, Report No. 1, Vol. 2, pp. 942-950.

vision over such legislation and the behaviour of the professions and occupational groups to ensure the implementation of provincial health policy.

Regulation Policy

The heart of contemporary and vital regulation of health legislation is, of course, policy and the Committee is convinced that policy considerations in the legislative scheme of the healing arts must remain a matter for government to be fulfilled by a restructured Department of Health headed by a Minister who is a member of the Executive Council and, like all Ministers, answerable to the Legislature. Until quite recently, the Minister has been a physician. We do not recommend that the Minister should never be a professional person in the healing arts because it is not our desire to restrict the unfettered discretion of a Prime Minister or to eliminate any competent candidate for the position. We feel obliged, however, to indicate we have discerned a feeling among many, if not most of the health professions, other than medicine, that their interests and submissions may not be considered as favourably as those of the medical profession because of the membership of the Minister and his principal advisers in the Department in the medical profession. While we think it likely that the medical profession will always deserve and be accorded great respect in the assertion of the views on health policy, there may indeed be much to gain by dispelling the appearance of disproportionate influence of the medical profession by reason of the constitution of the senior levels of the Department of Health.

Whatever means are eventually employed to supervise the machinery by which the various professions and occupational groups are governed, it is essential to recognize that the responsibility of government is not merely to take action when problems arise and at all other times to assume only a nominal responsibility for the organization and functioning of the regulatory bodies. It is obvious to the Committee that it will not longer suffice to settle for ex officio membership of the Minister or his appointee on Councils or Boards of the various regulatory bodies of the professions and occupational groups. In the interest of a coordinated health program, the continuous growth of independent governing bodies should be stopped. On those governing bodies which, for the reasons already advanced, should continue, at least for the immediate future, to be self-governing, there must be effective public representation and this representation should be by persons who are not themselves members of the professions or occupational groups concerned. Furthermore, the appointment of such representatives should be a governmental function and although, because of that fact, it would be unseemly to encumber the power of appointment, it is perhaps acceptable to require that the public be represented by a sufficient number of "lay" representatives to make their presence felt without diluting the professional membership on the governing bodies to the point where it forms a minority of the members. At the same time conscious efforts should be exerted, when exercising the power of appointment, to choose persons

who are public spirited and endowed with ability and desire to participate actively in the affairs of the body to which they are appointed. Public participation, and not merely public representation, should be the goal of such appointments. We concur with the recommendation of the McRuer Report[59] that "The principles of the British Medical Act, 1956, should be followed by making provision for the appointment of lay members to each of the governing bodies of the self-governing professions and occupations."

Recommendations:

314 That as a general rule the pressure created by occupational groups in the health field not now enjoying the status of self-government to be given self-regulatory powers ought to be resisted.

315 That those professions and occupational groups which are now or are to be self-regulating ought to be required to include on their governing bodies lay members to be appointed by the government in sufficient numbers to ensure effective rather than nominal representation of the public. Lay appointees should not, however, constitute the majority of members on such bodies.

316 That in making appointments of lay members to the governing bodies of self-regulating professions as recommended in Recommendation 315 it should be borne in mind that the quality of the persons appointed is perhaps more important than the number, and conscious efforts should be exerted to choose persons who are endowed with the ability and desire to participate actively in the business of the bodies to which they are appointed.

Regulation in the Light of Contemporary Needs

The prime purpose of the system of regulation which we have adopted in Ontario, as particularly exemplified by licensing, is to ensure competence among licensed practitioners. The statutory licensing bodies have been empowered generally to execute three tasks, all directed to the end of ensuring quality:

1) Determination of the educational program which aspiring practitioners were required to pursue.

2) Examination of the products of that program for licensure.

3) Discipline by, for example, the suspension or revocation of the right to practise because of professional misconduct which often includes, and should always include, incompetence.

Many changes in society and in society's attitudes, the organization of the professions and the practice of the professions have taken place since these powers

[59] *Ibid.*, Report No. 1, Vol. 3, p. 1209.

were first conferred on the self-governing bodies which regulate the professions and it would now be appropriate to re-examine the three different tasks. It is unnecessary to review fully the history of education for the professions but a few of the significant features should be alluded to. As developments in the other professions in large measure were patterned after the various stages of growth of the medical profession, the latter, for our present purposes, may be taken as the model. Originally, the educational system through which a person intending to practise medicine had to go in the early days of the colony was characterized by apprenticeship. The apprentice studied under a qualified practitioner unless he was a graduate of an English university or was an army physician. With the growth of the population, it became feasible for a practitioner to "teach" several students and the proprietary school came into existence. Some of them became faculties of medicine in universities but the most significant historical event in this development was the publication in 1910 of the Flexner Report on Medical Education in the United States and Canada, a report to the Carnegie Foundation for the Advancement of Teaching. The devastating criticism of a large number of American medical schools which the Report made is well known, as is the fact that, as a consequence, many of the proprietary schools were closed down and many other schools were greatly improved. Of the three Ontario medical schools then in existence, the resources available for maintenance of two of them — Western and Queen's — came from fees, only that of the University of Toronto being supported out of the general funds of the university. The verdict which the Report returned on Canadian medical schools in general was as follows:

> In the matter of medical schools, Canada reproduces the United States on a greatly reduced scale. Western University (London) is as bad as anything to be found on this side of the line; Laval and Halifax Medical College are feeble; Winnipeg and Kingston represent a distinct effort toward higher ideals; McGill and Toronto are excellent. The eight schools of the Dominion thus belong to three different types, the best adding a fifth year to their advantages of superior equipment and instruction.
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> At this moment the needs of the Dominion could be met by the four better English schools and the Laval department at Quebec. Toronto has practically reached the limits of efficiency in point of size; McGill and Manitoba are capable of considerable expansion. The future of Kingston is at least doubtful. It could certainly maintain a two-year school; for the Kingston General Hospital would afford pathological and clinical material amply sufficient up to that point. But the clinical years require much more than the town now supplies. Its location—halfway between Montreal and Toronto, on an inconvenient branch line—greatly aggravates the difficulties due to the smallness of the community. The rapid development of the Northwest Territory will undoubtedly hasten the growth of the Winnipeg school; other institutions will in time be established nearer the Pacific coast as the country grows in population.
>
> The legal standard in the Dominion has not thus far been high; but it has practically been elevated a year by the general movement to prolong the course to five years. Meanwhile, the high quality of instruction offered by

> McGill and Toronto to students who enter on less than a four-year high school education proves that our trouble in the United States has been at bottom not less one of low ideals than of low standards.[60]

While the Faculty of Medicine of the University of Toronto, which was established in 1843, at the time of the Flexner Report was an organic department of the University with entrance requirements of the Junior Matriculation Examination, strictly enforced, the Medical Department of Queen's University, organized in 1854, was described by Flexner as having a "relation — to the University (that) is anomalous, marking a period of transition that is likely soon to result in complete integration",[61] with entrance requirements that were said to be "somewhat below that of the arts department of the University, though students must comply with the requirements of the province in which they expect to practise."[62] The Medical Department of the University of Western Ontario, established in 1881 was described by Flexner as "(p)ractically an independent school" with entrance requirements that are "nominal".[63] Since then, the changes have been rapid and salutory. The University of Ottawa's medical faculty was created in 1945 and McMaster University in Hamilton first opened its doors to first year medical students in 1969. All medical schools in Ontario are now integral parts of universities that are provincially supported so that no longer are their faculties dependent upon the meagre resources which students' fees and gifts provide. All of them, indeed all Canadian medical schools, are subject to the supervisory jurisdiction of their respective universities as well as of an accrediting body of high standards, the Joint Accreditation Council of the Association of American Medical Colleges and Council on Medical Education and Hospitals of the American Medical Association, which in effect, requires medical schools to live up to high North American standards. Furthermore, all medical students in their final undergraduate year are examined by the Medical Council of Canada as well as by their own faculty. Liaison between Canadian medical schools is strong and is brought about by membership in the Association of Canadian Medical Colleges. It is perhaps even stronger by reason of the Committee of Presidents of Universities of Ontario and more particularly as a result of regular meetings of the Council of Deans of Ontario Faculties of Medicine. Conditions are today far better than they were in 1910 when Flexner had to write:

> A model state board law must therefore guard the following points: the membership of the board must be drawn from the best elements of the profession, including—not, as now, prohibiting—those engaged in teaching; the board must be armed with the authority and machinery to institute practical examinations, to refuse recognition to unfit schools, and to insist upon such preliminary educational standards as the state's own educational system warrants. . . .

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[60] Flexner, *Medical Education in the United States and Canada,* the Carnegie Foundation for the Advancement of Teaching, New York, 1910, pp. 325-326.

[61] *Ibid.*, p. 322.

[62] *Ibid.*

[63] *Ibid.*

That it was at one time essential that the "Colleges" or licensing bodies in the senior professions, whose practitioners are today university-trained, should have and exercise powers to directly or indirectly accredit the educational institutions, dictate preliminary educational standards, prescribe curricula, and examine applicants for licences who were the products of the educational institutions so accredited admits of no doubt. But what was once necessary has now become redundant.

Again taking medicine as the model, the nominal control of the licensing body, the College of Physicians and Surgeons of Ontario, over curriculum and examination is today not as necessary or essential in the interests of maintaining quality as it was when there was no responsible public or quasi-public body actively involved in these matters. But the Medical Act in these respects, as in so many others, remains unchanged. It will be remembered that the educational and examining functions of the College of Physicians and Surgeons of Ontario were first conferred by the Legislature in 1866. The Ontario Medical Act, in substantially its present form, was enacted in 1869 when the College of Physicians and Surgeons of Ontario became the governing body in place of the predecessor General Council of Medical Education and Registration created under the Medical Act of Upper Canada in 1866. No significant change in the legislation reflected the very significant changes which resulted from the Flexner Report in 1910, the year which MacFarlane et al. rightly characterized as "the beginning of a new era in medical education in North America in which all of teaching and research would aspire to performance according to the best standards of the university; a process by no means complete in all respects yet".[64] All the available evidence convinces us that effective control over medical education is today in the hands of those best equipped for the task, the medical educators, and whatever the shortcomings in medical education, and that there are shortcomings the medical educators whom we have heard and read are only too painfully aware, the task is being attended to responsibly. On the other hand, today it is difficult to see what skills or special knowledge the members of the licensing body as such (there is representation on the Council of the College of Physicians and Surgeons of medical educators) bring to the determination of what the medical student should be taught to ensure quality in the profession.

It is, then, surely arguable that in the light of modern conditions in medical education, the Medical Act should be amended to reflect the realities of life, not only because of a sense of neatness which dictates that archaic provisions of a statute should be removed, but also to give emphasis to the roles which the licensing body will continue to play and must play more effectively.

With the education, at public expense, of students in professional courses occurring in provincial universities whose professional courses are subject to the

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[64] J. A. MacFarlane et al., *Medical Education in Canada*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1965, p. 18.

scrutiny not only of the senates or governing academic bodies of the universities but also of concerned and knowledgeable accrediting agencies, there should, in our view, be a termination of the supervision exercised by the licensing bodies over the schools. It is our conclusion that regulatory bodies of the practising profession, consisting largely of elected members of the profession, should confine their concern to the regulation of the practising profession, and to an assessment of the competence of applicants for licensure who have been trained elsewhere than in Canadian professional schools. In arriving at this conclusion we have not overlooked or failed to consider carefully the danger that by freeing the university professional school from the control of the licensing body, there may be removed a safeguard against the school becoming exceedingly theoretical, "academic" or "ivory-towered" with the result that their products will be less competent to deal with the practical problems of caring for their patients.

Recommendation:

317 That control by the licensing bodies of the professions over the admission requirements of the publicly supported professional schools and over their curricula should be terminated. The concern of the regulatory bodies of the practising profession should be confined to the regulation of the practising profession and to an assessment of the competence of applicants for licensure who have been trained elsewhere than in Canadian professional schools.*

The relationship between the universities and the government, whose concern must be the cost of professional education on the one hand and the training of adequate numbers of professional persons on the other, is an extremely delicate one, calling for sympathetic understanding on both sides. Respect for academic freedom and its concomitant benefits to an enlightened society should restrain the government, no matter what pressure it may be under to see to it that the necessary practitioners are produced on the most economic basis, from direct involvement in the affairs of the professional school as an integral part of an institution that must be concerned with the primacy of education rather than training. Similarly the professional school must not lose sight of the reality that though its role is primarily educational, society does expect that its products will possess certain skills which must be put to direct, practical use for the benefit of members of society. We see no reason to be less than optimistic that this delicate balance can be maintained. Given the association of the professional school with the necessary clinical facilities in which the student is exposed to the patient needing care, there will always be a practical necessity to avoid an overly theoretical approach. If our optimism should prove to be unwarranted, we are satisfied that there is a built-in safeguard against these dangers in our recommendation that there should be a constant and continuous examination of the adequacy of the functions being performed by the various parts of the health care system.

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*See minority opinion, pp. 217-220.

There is another important value to be realized by the "separation of powers" which we are recommending, a value which in itself, or standing alone, could not justify our approach but will be a beneficial by-product of it. We have discerned among the public and, particularly among well-informed and articulate members of the public, an impression that the cause of the shortage in physicians and of the consequent high cost of their service is a deliberate and concerted imposition of a limit on the numbers of graduates of medical schools, either by limiting the numbers of entrants to medical schools or by imposing a high attrition rate on medical students. The "conspiracy" between the medical schools and the "profession" to ensure a high economic return to the profession is a popularly held belief, and may even find some justification in past expressions of members of the medical profession. That there is no basis and has for a considerable period of time been no basis for this view is our firm position. The medical schools are more than concerned about the importance of meeting the needs of society for more practitioners. It is not within their reasonable power, given their present resources, particularly faculty, to provide places for all those applicants for entry to medical schools who are qualified for admission but who cannot be accommodated at the present time. The obligation of finding room for such applicants is neither that of the licensing body nor of the medical schools but rather that of government with the necessary cooperation of the medical schools. We have no reason to believe that the cooperation will not be willingly forthcoming. The main point to be made here, however, is that by formally eliminating the control of the licensing authority over the educational responsibility, an elimination that in fact, though neither in law nor in theory, was accomplished some considerable time ago, an emphasis will be given to the proper and efficient allocation of responsibility, and the basis of any suspicion of limitation of numbers as a matter of self-interest will be eliminated.

It is because of our concern for establishing a distinct demarcation of authority and responsibility that we have recommended that a clear distinction be made between the functions of the licensing agency — the trustee for the public, and any voluntary professional organization — the spokesmen for the profession. Accordingly, it ought not to be possible for the licensing body to fix an amount for membership dues or fees at a figure which will enable it to pay a per capita sum to a voluntary association, and thus in fact require as a condition of holding a licence that the licensee be a member of, or at least financially support, the voluntary association. It is for the same reasons, and with the same end in view, that in the case of the non-university prepared disciplines we have generally recommended against granting to a voluntary association the right to license or certify its members as fit to practise. We have concluded that the most appropriate agency to be charged with this responsibility would be a single and public agency and one, moreover, whose members were appointed. We will have more to say about this agency later in this chapter.

Recommendations:

318 That in the regulation of the health professions and occupational groups the principle be recognized that a clear distinction must be made between the functions of the licensing or qualifying agency, the trustee for the public and the voluntary professional organization, the spokesmen for the members of the profession or occupational group.

319 That no licensing or qualifying body be permitted to fix an amount for membership dues or fees at a figure which will enable it to pay a per capita sum to a voluntary professional association and thus, in effect, require that, as a condition of holding the qualification to practise, the practitioner be a member of, or at least support, the voluntary association.

320 That in the case of the non-university prepared health disciplines no voluntary association should be accorded the right to license or certify its members as fit to practise.*

Continuing Competence

The validity of what we propose about the duties of the licensing body with relation to continuing competence of practitioners does not in any way depend upon the acceptability of the recommendations we have made regarding the withdrawal of powers in the field of education and examination. Everywhere apparent in the professions is the increasing recognition of the wisdom of ensuring competence of the practitioner at stages of his career subsequent to initial qualification. This recognition results not only from the accelerating pace of new developments in the practitioner's field, which is evident in the widely quoted statement that medical or scientific knowledge doubles every ten years, but also from the realization that it was never a responsibility that was entirely satisfactorily discharged. But the issue today is not whether a practitioner once licensed should be required to submit to continuing education so that his knowledge does not become obsolete but rather what feasible means ought to be employed to this end. The existing formal mechanisms are quite inadequate for this task. These have been the powers of discipline for professional misconduct. The most glaring defect of this type of control is that it operates only after the practitioner's incompetence has allegedly manifested itself. It is not a preventive measure except to the extent, if any, that a practitioner consciously avoids undertaking a procedure for fear of falling afoul of a discipline committee. Moreover, the regulatory statutes are not consistent in characterizing incompetence as a ground upon which a practitioner may be disciplined. The Dentistry Act, for example, defines conduct for which a practitioner may be disciplined to include "professional incompetence, gross carelessness in diagnosis or treatment. . . ."[65] The Medical Act[66] subjects a practitioner to

*See minority opinion, pp. 217-220.

[65]As amended by 1966, c. 38, s. 1.

[66]As amended by 1965, c. 69, s. 3.

disciplinary consequences for "professional misconduct" which includes "misconduct in a professional respect or of conduct unbecoming a medical practitioner or of incompetence" but not carelessness or gross carelessness. The Pharmacy Act,[67] on the other hand, empowers the Council on the Discipline Committee to discipline a practitioner who "has been guilty of negligence, incompetency or improper conduct in a professional respect". The inconsistencies are curious. Mere negligence, which involves no conduct of a morally blameworthy nature, is enough to cause the cancellation of a pharmacist's registration. For a dentist, however, what is required is gross *carelessness,* which presumably is either the same as, or more, but not less, serious than gross *negligence*, a legal term often encountered but difficult to apply. But a physician need not fear, as the other two types of practitioners apparently must, the consequences of negligence or gross carelessness that fall short of incompetence. In any event, quite apart from the difficulties inherent in the problem of establishing incompetence, the isolation in which so many practitioners practise makes it highly unlikely that their incompetence will be discovered until after some damage has been done.

A similar objection can be made about an informal control that in the U.S. literature is commonly accepted to be a measure of quality control — namely, the malpractice action. This is simply an action against a professional person for damages for negligence resulting in harm to the patient. The test of liability may, for present purposes, be said to be whether the practitioner in question did some act which a prudent and reasonable practitioner of his kind would not do or whether he omitted to do some act which a prudent and reasonable practitioner would do. Put another way, it is merely whether the practitioner's conduct in question fell below that standard of care which may be expected of a reasonable practitioner of his kind. In the United States, damage actions against professional persons and particularly medical doctors are so commonplace and awards are so large that the malpractice action must be considered to be a constant source of worry to professional persons quite apart from the directly felt effect on their expenses by reason of the size of the premiums involved in purchasing liability insurance. But more important perhaps is the effect on the quality of practice which an understandable fear of being sued produces. Rather than operating as a quality control it may reasonably be argued that the malpractice action has reduced the quality of medical care. It has, for example, been stated, and it is an entirely plausible statement, that many American physicians deliberately avoid some valuable investigative procedures and some forms of treatment because though some demonstrable residual signs are harmless, in individual instances, they can be made to appear as potentially harmful sequelae. The point to be made, however, is that though expressions of concern about the malpractice action are common among Ontario practitioners, the actual incidence of such proceedings, both threatened and real, is quite low. For example, although in 1967 there were approximately 24,000 licensed medical doctors in Canada, there were fewer than sixty-five malpractice

[67]R.S.O. 1960, c. 295, s. 29(1) (c) as amended by 1966, c. 115, s. 6(1).

actions commenced. Of these it may be realistically assumed that only a small fraction will culminate in judgments against the practitioner. Table 25.1 is a yearly breakdown of malpractice litigation in all of Canada, an examination of which demonstrates the unimportance of this type of litigation in Canada when measured against the magnitude of the problem in the United States. It is unnecessary to go into much detail in looking for the differences between the incidence of litigation in the two countries. It will suffice to say that there are certain aspects of civil litigation that are probably so significant in their differences as between the two countries that they must be considered to be factors explaining the differences, such as, for example, the method of trial (jury in the U.S. versus non-jury in Ontario), problems of evidence (greater readiness in the U.S. to rely on evidentiary principle known as "res ipsa loquitur"), patterns of legal practice (the use in the U.S. of the contingent legal fee which is illegal in Ontario) and the role played by the Canadian Medical Protective Association as contrasted with that of liability insurance carriers in the U.S. In short, for all intents and purposes, the malpractice action may be ignored in any realistic assessment of the adequacy of existing quality controls.

The technique most often thought of for determining, and at the same time ensuring, competence is periodic re-examination. Another is limited licensure and we shall have more to say about this shortly. As to the former, however, we have heard and read enough about it to doubt seriously the efficacy of such a method. The examination system, even for the purpose of qualification for a degree, has been attacked so often and so successfully that an aversion to examinations is general in society. Apart from its unpopularity, which in itself is not sufficient reason for dismissing it in the continuing education context, it is clear that its major defect is that it tests only certain skills, and skills which may not be a true measure of the candidate's professional competence. Moreover, both in terms of examining personnel and time, which the candidates would take to prepare for their examinations which would otherwise be spent in their practices, examinations seem to us to be a wasteful use of scarce resources. In our view examinations would not be an effective means of proving continuing competence.

There is much to be said in favour of limited licensure in the senior health professions both as a quality control and as a method of simplifying the problem of continuing competence and, in addition, as a partial solution to the vexing problem of the foreign graduate. Without rehearsing all the arguments for and against limited licensure, for we have dealt with this subject elsewhere in our Report,[68] for the purpose of this chapter we content ourselves with saying that while we favour the concept of limited licensing and would like to see it universally endorsed so that, for example, it would no longer be possible for a graduate of a medical school to be licensed for the full spectrum of practice in medicine, surgery and midwifery but only in a circumscribed area of one of these disciplines, we have rejected it as a practical answer to our problems basically for two reasons. The

[68]Recommendation 16, Chapter 8.

TABLE 25.1

Malpractice Litigation in Canada (Yearly Breakdown)

	Awards			Settlements			
Year	No.	Amount	Average	No.	Amount	Average	No. of members
1967	—	—	—	—	—	—	18,265
1966	—	—	—	—	—	—	17,275
1965	1	2,500	2,500	14	124,797	8,914	16,270
1964	1	14,796	14,796	10	103,773	10,377	15,043
1963	2	94,008	47,004	7	12,937	1,848	14,305
1962	6	228,084	38,014	2	4,100	2,050	13,609
1961	—	—	—	3	9,227	3,076	12,947
1960	—	—	—	4	7,950	1,988	12,243
1959	1	2,756	2,756	7	17,744	2,535	11,500
1958	1	2,374	2,374	3	16,152	5,384	10,776
1957	—	—	—	1	6,068	6,068	10,145
1956	—	—	—	2	2,150	1,075	9,403
1955	—	—	—	1	850	850	8,983

[1]Canadian Medical Protective Association.

SOURCE: Canadian Medical Protective Association.

Disposition of Cases								
No. of writs served	pending	dismissed	(Court) discontinued	Lost	Appealed	Settlements CMPA[1]	Settlements Others	No Progress
64	58	3	1	—	—	1	—	1
28	18	4	3	—	—	1	5	1
43	22	7	1	1	1–dismissed	11	8	8
43	13	9	3	1	—	10	5	10–1 writ expired
31	11	5	3	2	1–lost 1–dism.	7	5	6
35	1	10	4	6	3–dism. 3–pending	2	3	12
17	1	6	2	1	1–won	3	3	4
19	1	4	1	—	1–dism.	4	3	8
27	—	6	1	1	1–dism.	7	6	10
13	—	4	1	1	—	3	2	3
9	—	3	—	—	—	1	2	5
9	—	3	2	—	—	2	3	2
8	—	2	2	—	—	1	1	3

first is that there are so many under-services areas in the province that until and unless a well-organized regional form of group practice encompassing the skills of many different kinds of health worker exists and covers all parts of the population it would exacerbate the existing shortage of health care in sparsely serviced areas if the full range of practice now known were discontinued. Second, and this is perhaps more important, the health professions in Ontario are practised in the context and the traditions of practice prevailing, if not internationally, at least on a North American scale. It will not be feasible to institute limited licensure until it is adopted generally in the North American context. This is a matter that should be given serious consideration by federations or associations of licensing bodies in the same discipline because unless there is general agreement it is not likely that any single jurisdiction would want to incur the risks that would inevitably be associated with pioneering such an innovation.

We are left, then, with the task of devising means other than those we have rejected for accomplishing the same ends. In the field of continuing education, no one method is likely to be adequate and it may be necessary to resort to a multitude of measures. As we see it, the prime purpose of these measures is to induce the practitioner to involve himself in refreshing and augmenting his store of knowledge in a meaningful way. Token attendance, for example, at periodic refresher courses in compliance with a statutory requirement would not be sufficient. What is wanted is more than mere physical presence.

The first point of time at which attention can be paid to the questioning of continuing education is at the outset of the practitioner's career, that is, in the professional school. It is here that professional habits of thought are first acquired. In the case of medicine, once again used as a model, there is ample evidence that the medical student's teacher is aware of the importance of updating one's knowledge and this, it seems to us, is inevitable in a teaching environment such as a medical school and the teaching hospital. While it is impossible to legislate in this area it is possible and desirable to express the hope that the teachers make a positive effort to inculcate the habit we are concerned with. The student is extremely sensitive to the views of his teachers and thus receptive. In the words of a second-year medical student published in a student newspaper[69] during the Committee's deliberations: "The medical school scene is admirably suited to inculcating these sorts of values since the student tends to learn attitudes and outlooks from his clinician unconsciously at the same time as he picks up technical knowledge consciously." In addition to this sort of communication between teacher and student, it would be highly desirable to find a place in the undergraduate curriculum, already crowded as it is, for a course on the history of the profession of medicine, designed to show the dynamic nature of the practice of medicine, the delicate relationship between the relatively stable art and the fast-changing science with emphasis on the pioneering breakthroughs of researchers which periodically

[69]*The Varsity*, University of Toronto, October 16, 1968, p. 5.

demonstrate the tentative nature of accepted tenets and the fallacies of beliefs widely held in the past. While the need may not have the same urgency in other university health disciplines as in medicine owing to the higher rate of change in medicine, corresponding courses might well be considered in other disciplines and with the same end in view — namely, to illustrate the extent to which competence is related to the possession of knowledge of developments in practice since the time of original qualification for admission to practice.

In the realization that not all practitioners need or can profit by the same course or courses in a continuing education program we have recommended that though "continuing education" be made compulsory by being made a condition of re-licensing, generally for all professions and occupations in the health field, or at least for the senior professions, the program of continuing education should be as flexible as possible. While general education may be commendable and accordingly is something to be encouraged, it must remain a matter for the conscience of the individual practitioner. Our concern is not with his general knowledge but rather with his knowledge of the area in which he practises or performs services. Different programs will be required for different groups of practitioners within the same profession. In our opinion it would be unwise to attempt to lay down a formula to be followed in pursuing the end which we are recommending. It may be that for a given group of practitioners, a course of lectures or of instruction would be best, for another group, institutional practice for a period of time, for yet another, the very nature of the services being rendered is a sufficient guarantee, and for a further group the presentation of a scholarly paper and so on. The chief difficulty we see in our proposal lies in the designation of the authority to be held responsible for certifying that the individual practitioner has complied with the requirement devised for him or his group of practitioners. Competence for this new task is the criterion by which the agency should be selected and we think that the application of this criterion dictates that the educational institution must be given the task. We have no doubt that in discharging such a new responsibility, for the first time as a matter of duty rather than voluntarily, the educational institution will likely enlist the advice of other competent bodies that, together with the educational institution, constitute the profession or occupational group. We do not however, recommend that such enlistment be made a requirement because we wish to avoid the imposition of fetters on its judgment as to an appropriate program.

The implementation of our recommendation in respect of continuing competence will, of course, impose a heavy burden on the educational institutions and particularly on their departments of continuing or postgraduate education. It is particularly important that this new burden should not be permitted to involve a sacrifice of any effort in or attention to the undergraduate and graduate departments. To ensure that obligatory involvement in continuing education will not be at the expense of the institution's traditional roles, significant increases in staff or faculty and in budgets will be necessary. For those professions whose practitioners are educated in universities our proposal may even involve a reconsideration of

the delicate relationship between the university and society and, because of its financial aspect, between the university and government. The chief point to be made in a chapter on regulation is that the licensing or certifying body for the profession or occupational group should be required, after initial qualification for practice, to insist on the periodic production of evidence from the educational institution that the practitioner has satisfied the continuing education condition laid down by that institution before he is relicensed or recertified.

Recommendations:

321 That compulsory participation in programs to ensure continuing competence, designed to be as flexible as possible and to relate to the particular area of practice engaged in by the practitioner, be made a condition of relicensing for all professions and occupations in the health field generally, but at least for the senior professions.

322 That the responsibility for designing and carrying out the program of continuing education and for certifying to the licensing or regulatory body of the profession that the individual practitioner has complied with the requirement devised for him or his group of practitioners, be conferred on the respective professional educational institutions.*

323 That to ensure that programs of continuing education not be undertaken at the sacrifice or prejudice of the quality of undergraduate and graduate instruction, the staff, faculty and budgets of the educational institutions be increased to make them commensurate with the magnitude of their highly essential responsibilities, both old and new.

Regulation Reform

Our proposals for the reform of the regulation of the healing arts should be read against the background of our recognition that structural change in itself is not a panacea. Any attempt to bring about a more orderly and rational organization of the means by which the services of health care practitioners are provided or made available that amounts to nothing more than legislation amending the regulatory statutes is doomed to failure. Much more than a change in formal structure is required and the recommendations to be found in the other chapters of this Report are an essential part of a program of reform. What we must emphasize here, however, is that, though by itself it is insufficient, reform of the legal structure is an indispensable condition. For some of the structural modifications we have suggested the basis is self-evident; for others we have expressed or shall express our reasons. For the moment, we should like to point to two important considerations which must be kept in mind when steps are taken to facilitate or rationalize the health care system in our society. The first is that every effort should be made to focus the attention of all professionals on the true role of the various official regulating agencies as delegates of the legislature to act as trustees for the public interest.

*See minority opinion, pp. 217-220.

The second is not unrelated to the first, and is that one of the chief objects of regulation in the future must be to enhance the confidence of the public in the competence, integrity and social responsibility of the professions and occupational groups by removing any basis for any suspicions, which we have found to be widely, though perhaps not entirely justifiably, held among the public,[70] that the various facets of the pluralistic professions, namely the educational institution, the licensing body, and the voluntary association, work in concert to ensure the primacy of the professional interest over the public interest in the provision of the services which are adequate both in quantity and quality.[71]

Much of our task has been made easier by the publication of Report No. 1 of the Royal Commission Inquiry into Civil Rights, the McRuer Report. Section 4 of Volume 3 of that Report deals in considerable detail with a significant aspect of our terms of reference, the regulation of the self-governing professions and occupations in the health field. In general we adopt the analysis of the problems contained in section 4 and endorse the recommendations found there with only a few qualifications. These qualifications arise, we think, by reason of our concern with a narrower focus than the McRuer Commission had as its terms of reference included all the professions and occupations while we were occupied only with those in the health sector of our society. Another factor explaining our differences of opinion was the fact that unlike the frame of reference of the McRuer Report, we were not constrained by a purely legalistic examination of the professions and occupations. In any event our differences of opinion are very few in number. We have already referred to one, namely that we do not agree that citizenship should be a condition precedent to qualification for office in the various statutory regula-

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[70]See p. 51.

[71]The "professions" themselves express a sense of the loss of the public's confidence. We suggest that, to the extent that there has been a loss of confidence, one of the causes is the view, held by the public, of a monolithic rather than a pluralistic group, and the association of all members of a profession with the usually negative reactions to recommendations, originating outside the profession, for change. A recent example, at the time of writing is the published reactions of "spokesmen" for the "professions" against the suggestion of the Economic Council of Canada that as "a general rule, arrangements for determining the remuneration of self-employed professional and other groups should be subject to competition policy". One can perhaps find some evidence of the suspicion to which we referred in the following passage:

> Turning now to licensing and other ways in which control may be exercised over the entry of persons into professions and institutions for professional training, it is clearly in the public interest that a close watch be kept on quality standards in professions such as medicine and the law. It is equally clear that this watch must be kept to a large extent by persons who are themselves members of these professions and have the requisite knowledge and experience to perform the task properly. But there is also a public interest in ensuring that the power to regulate the quality of professional services is not used in an unduly restrictive way, and that the size of likely future needs for professional services is kept in mind. This aspect of the public interest is all the more relevant in an age when a large proportion of the cost of professional training is a charge on the general taxpayer.

Economic Council of Canada, *Interim Report on Competition Policy*, Queen's Printer, Ottawa, July 1969.

tory bodies. Another qualification we should like to express is with respect to the right of appeal.[72] While we do not reject this recommendation, our endorsement of it is less than enthusiastic for the simple reason that our examination of the decisions of the courts in matters relating to the disciplinary proceedings of professional licensing bodies gives us little cause to be optimistic that the courts, composed themselves of members of a profession, are likely to substitute their objective judgment for that of the tribunal whose determination they are reviewing. In the past the courts have tended to defer to the judgment of the disciplinary body as being more likely than anyone else to possess the necessary expertise and standards of judgment. In our view, a desirable review is one which re-examines the very standards by which the regulatory body passes judgment. Furthermore, as we have shown, we do not accept as valid, some of the expressions of the courts as to the purposes of regulation.

But while our endorsement of the appeal recommendation in the McRuer Report is not especially enthusiastic it remains, nevertheless, an endorsement. It is to be hoped that the other changes proposed with relation to the constitution of the licensing and disciplining bodies will have a salutary effect on the preparedness of the bodies themselves to reappraise the standards by which the conduct of their members is judged and thus make an objective review on appeal less necessary. Essentially what we have in mind now is the tendency of professional ethics to concern themselves with relations among members as, for example, in their almost undue attention to unprofessional practices such as advertising, in the entirely genuinely held belief that such a concern is in the public interest. Whether the prohibition allegedly breached by the practitioner is itself socially desirable ought to be the subject of attention as much as the question whether the practitioner did in fact breach it. The qualification which we desire to see added to the McRuer recommendation is that in any statutory amendment implementing the recommendation, there be set out a provision that the appeal is intended to be a complete appraisal not only to see whether the evidence supported the finding attacked on appeal but also of the reasonableness, as examined from the point of view of the public interest only, of the standard in respect of which the practitioner was judged. The precaution which we are here advocating might possibly be redundant if the self-governing bodies' codes of ethics or statements of what constitutes professional misconduct, which the McRuer Report recommends be circulated to the members[73] and made available to the public, required the examination and approval of the Lieutenant Governor in Council and were specific in their definitions of misconduct.

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[72]McRuer Report, *op cit.*, Report No. 1, Vol. 3, Recommendation No. 23: "There should be a right of appeal from all disciplinary decisions, and decisions refusing admission. The appeal should be to the Appellate Division of the High Court of Justice, in accordance with recommendations in Chapter 44."

[73]McRuer Report, *op cit.*, Report No. 1, Volume 3, p. 1190. See also its Recommendation No. 9, p. 1209.

It is clear from what we have said throughout this Report that we entirely agree with the view expressed in the McRuer Report[74] that the power of self-government ought not to be extended beyond its present limitations unless it is clearly established that the public interest demands it. Indeed, if we could start from the beginning we would be inclined to prevent the rise of self-governed as opposed to provincially licensed, professional groups. We do not think that it would be feasible, however, given the history and traditions of the professions, to abolish self-government. We have expressed and reiterate our concern to avoid unnecessary action which will result in damage to professional pride without which professional services would deteriorate. It was with these considerations in mind that we have dealt with regulation in each of the chapters in Volume 2 of this Report devoted to the individual disciplines. We recommend as an alternative to complete self-government for every discipline a scheme which retains self-government for some disciplines, extends it to others and creates a new regulatory agency to be known as the Health Disciplines Regulation Board for the regulation of the remaining disciplines. The reader will have observed when reading the chapters on the individual disciplines that in the determination, whether a given discipline is to be self-governed or regulated by the Health Disciplines Regulation Board, there is an absence of consistency. A sense of pragmatism dictated that rather than opting for a neat, consistent conceptual system of regulation that would work on paper, but perhaps only on paper, we elected to deal with each discipline on its own merits. The reasoning behind our individual decisions will be found in the relevant chapters.

Health Disciplines Regulation Board

For the regulation of many of the disciplines we recommend the creation of the Health Disciplines Regulation Board. The disciplines to be under the jurisdiction of this new agency are dental hygienists, dental technicians, nursing assistants, pharmacy assistants, ophthalmic dispensers, chiropodists, physiotherapists, occupational therapists, remedial gymnasts, massage therapists, speech therapists, audiologists, medical record librarians, health technologists, osteopaths, chiropractors, and hypnosis technicians, nutritionists.

Our concept of the Board is that it should be an administrative tribunal with quasi-judicial powers and that it should occupy the same relationship with the Department of Health that the Ontario Labour Relations Board occupies with relation to the Department of Labour or the Ontario Municipal Board occupies with relation to the Department of Municipal Affairs. To put it another way we see the Board as one which, though possessing independence from interference in its affairs from a government department is nevertheless the chosen agency through which government's health-disciplines policies are administered. To carry out its functions properly it will require several divisions. The Board itself should be small in size consisting of perhaps no more than five appointed members one of whom should be the chairman and all of whom should be full-time members. It should

[74] *Ibid.*, p. 1162. See also its Recommendation No. 3, p. 1209.

have a chief administrative officer and a secretariat sufficient in size and quality to carry out all its functions including the functions of each of its divisions. The members of the Board need not be members of any of the health disciplines falling within its jurisdiction (it would be unwieldly in size if each of the disciplines were represented on the Board) and indeed they need not be members of any health discipline. It would, however, be advisable to avoid having a physician on the Board, if only to remove the opportunity of alleging medical domination. Serving under the Board will be a number of divisions, one for each discipline regulated by the Board. Each of these divisions should contain appointed non-members of the discipline concerned but a bare majority of the division members should be appointed members of the discipline regulated by it. It will be the function of these divisions to be responsible for the decision-making involved in the licensing, certifying or registering, as the case may be, of the practitioners and, as well, in the disciplining of the practitioners. The divisions would, of course, have the further responsibility for drafting, with the assistance of necessary regulations and rules for submission to the Board which, if satisfied with the content of the draft regulations respecting a particular discipline, will be responsible for submitting them to the Lieutenant Governor in Council where, it is to be hoped, they will receive another independent scrutiny. Appeals from a division's decision may be taken by any person affected to the Board itself, which, when acting as an appellate tribunal, should be augmented for a particular appeal by members of the discipline concerned who may not, however, be members of the division appealed from. We do not think that additional members should form a majority but there can be no objection to having more than one member of the discipline sitting on the appeal. If the Board should consist of five members it should be augmented by as many as three members of the discipline. From the decision of the Board, an appeal may lie to the court in the manner suggested by the McRuer Report.

It will be noticed that essentially what we are recommending is a new body but a body which is not unlike bodies which have been known in Ontario and elsewhere. Some of the features of our proposed Health Disciplines Regulation Board were found in the original Board of Regents under the earlier Drugless Practitioners Act of Ontario and others may be found in the United Kingdom's Professions Supplementary to Medicine Act 1960.[75]

An alternative solution to the problem of the "balkanization" of the health disciplines, but one rejected by the Committee, is the creation of a general regulatory agency with jurisdiction over all the disciplines including those which traditionally have been self-governed. We have indicated our reasons for refraining from abolishing self-government, but it must be conceded that if all disciplines are not placed under the same regulatory agency certain problems, largely but not exclusively, of an interdisciplinary nature, will remain unless a satisfactory authority

[75] 8 & 9 Eliz. 2, c. 66.

is charged with the responsibility of attending to them. It is because of our recognition of the continuing existence of some of these problems that we recommend the creation of an office of Health Commissioner.

Recommendations:

324 That a Health Disciplines Regulation Board be created for the regulation of those disciplines for whom public regulation has been recommended in Volume 2 of this Report.*

325 That the Health Disciplines Regulation Board be an administrative tribunal with quasi-judicial powers occupying a relationship with the Department of Health that is similar to the relationship of the Ontario Labour Relations Board and the Department of Labour or of the Ontario Municipal Board and the Department of Municipal Affairs.

326 That the Board be small in size consisting of perhaps no more than five appointed members all of whom should be full-time members and one of whom should be chairman.

327 That the Board should have a chief administrative officer and a secretariat of sufficient size and quality to carry out all its functions including the functions of each of its Divisions.

328 That for each discipline regulated by the Board there should be a Division of the Board containing a bare majority of practitioners of the discipline regulated by that Division, the remaining members being non-members of that discipline.

329 That it be the function of each Division of the Board to be responsible for the decision-making involved in the licensing, certifying, or registering, as the case may be, and of the disciplining of the practitioners in its respective discipline.

330 That the Divisions of the Board be responsible for the content of the necessary regulations and rules for submission to the Board, which, if satisfied with such content, would be responsible for their submission to the Lieutenant Governor in Council.

331 That provision be made for appeals from the decision of a Division, by any person affected, to the Board, which when acting as an appellate tribunal would be augmented by members of the discipline concerned who are not, however, to form a majority and who may not be members of the Division appealed from. An appeal may lie to the Court, in the manner suggested by the McRuer Report, from the decision of the Board.

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*See minority opinion, pp. 217-220.

The Office of Health Commissioner

In order to substitute a greater degree of order for the chaotic conditions we have described throughout this Report in the regulation of the various disciplines with a view to a better integration of the provision of health services, it is apparent that a more rational system of regulation than we have hitherto seen must be created. The creation of such a system will, to persons accustomed to work in a disorganized or, perhaps more accurately, unorganized industry, appear to be the coming of a great bureaucratic machine destined to destroy all that is good in traditional patterns of practice, provision of health care and regulation of health care workers. Of course, we do not share such fears. But to the extent that the extreme form of independence, in the sense of absence of social supervision and effective quality control which has characterized the health professions until recently, will be diminished by the implementation of our recommendations, the loss, if loss it is, is the price of improving the availability to the public of a better quality of health care. To allay the worst fears of those accustomed to the absence of effective integration and regulation, and, at the same time, to provide a remedy for individual complaints that may well be justified, when the collective good is being emphasized for the first time, we propose the creation of the office of Health Commissioner. Our concept of this office is that it should be filled by a highly competent person, preferably with legal training, though not necessarily a member of the Ontario bar, with security of tenure and with a sufficient budget and staff to enable him to carry out his responsibilities efficiently. He should be given broad powers of investigation, including the power to call for, and inspect files and documents, over the whole health care system, including the Department of Health and all the regulatory agencies. To enable him to discharge this task with no suspicion of partiality, he should be independent of the Department of Health, and should have the power to publish not only periodic, say annual, reports of his findings to the Legislature, but particular reports of individual inquiries as well. In addition, it should be his role to attempt to mediate disputes between discipline and discipline, discipline and regulatory agency, citizen and discipline or regulatory agency, and practitioner or discipline and government. Where, for example, a member of the public complains about the conduct of a practitioner to that practitioner's disciplinary body and that body concludes that the complaint does not merit investigation, the complainant, who today has no remedy, would have access to the Health Commissioner to request a review of the propriety of the decision of the disciplinary body not to investigate the complaint. On the other hand, there are likely to be occasions when a practitioner will feel aggrieved about an act or refusal to act on the part of an agency or department of government or his own regulatory body. A grievance of this kind may also be brought within the jurisdiction of the Health Commissioner. There is, for example, no formal means by which a physician may today challenge the merits of a decision of the Medical Advisory Committee of a hospital or of the Credentials Committee respecting hospital privileges. We feel strongly that one of the best quality controls for the members of the medical profession is the sort of peer group review and continuing education that is provided by

membership in a hospital, and that, ideally, all members of the profession who can profit by membership should be entitled to it. Yet, today, the administrative structure of hospital practice prevents some physicians from becoming a member of staff. We think that there should be a right of appeal from an adverse decision on an application for hospital privileges, and from a decision reducing or abolishing a licensed practitioner's hospital privileges which, in certain circumstances, could be as effective an obstacle to practising one's profession as a revocation of his licence. We do not think, however, that it would be appropriate to confer jurisdiction to entertain such an appeal on the College of Physicians and Surgeons since we regard hospitals as institutions that are much more than the physician's workshop and accordingly, ought not to be subject to regulation by the body responsible for the licensing of physicians. We are of the opinion that an acceptable alternative to an appeal would be a review by the Health Commissioner whose conclusions would, by virtue of the importance of his status, likely be accepted by the persons or bodies concerned. It is true that the effect of this solution is to stop short of providing an enforceable remedy to an aggrieved person. But the existence of a policy of constant surveillance over the entire structure of the health sector by a revitalized Department of Health and by the Ontario Council of Health, as discussed in Chapter 24 should serve as a further sanction to accept the decisions of the Health Commissioner. Surely a body would ignore the determinations of the Health Commissioner at the risk of a change in legislation which might result in a tighter control or regulation over the conduct of the recalcitrant bodies.

Recommendations:

332 That the office or position of Health Commissioner be created to investigate complaints in the health sector and with the power to report the results of his investigations.

333 That the Health Commissioner be a highly competent person, preferably with legal training, though not necessarily a member of the Ontario bar, with security of tenure, and a sufficient budget and staff to enable him to discharge his responsibilities efficiently.

Some General Considerations

Our proposed reforms of regulation in the healing arts are intended to preserve and promote a healthy pluralism but one that would be able to bring about such a degree of integration as to have all the parts working towards the same end of providing high quality health care and dignified working conditions for the health personnel providing that care. The creation of a monolithic structure of regulation could theoretically ensure the provision of health care but, in our view, only at the expense of the maintenance of dignified working conditions which, in turn, would inevitably lower the quality of health care. But without a more centrally controlled system of regulation certain problems will remain and will require a

less direct approach to their solution. Earlier in this chapter[76] we referred to the statutory impediments in the way of an optimal allocation of responsibilities among the various practitioners in the health field and quoted with approval the views of writers who concluded that "in general, scope-of-practice issues are the most clouded areas in the legal regulation of health manpower, since they have not been adequately resolved by the licensure statutes or related court decisions". Since many of the regulatory statutes will continue to limit the scope of practice of the various occupational groups and since the Medical Act is to continue to prohibit anyone who is not registered under that Act from practising medicine, surgery or midwifery, which will remain undefined, occasions can and, we have no doubt, will arise when other personnel than physicians perform acts which lie beyond the legal scope of practice as defined in the governing legislation. But such acts, with changing technology, may well turn out to be not beyond their actual competence and, indeed, it is to be hoped that procedures which today are within the competence of physicians will tomorrow be within the competence of lesser trained personnel. In that event it would be a sad waste of scarce resources to continue to require licensed physicians to perform such tasks simply because of the rigidities of the law. It is our hope that continuing experimentation will take place, and pilot projects undertaken, to try out different mixes of personnel to do work formerly done by physicians only. We have recommended that henceforth violations of the Medical Act will be prosecuted not by the College of Physicians and Surgeons of Ontario but by the Crown Attorney.[77] As a safeguard against such power to prosecute being used to inhibit delegation of tasks to lesser trained personnel, or the undertaking of new tasks by personnel formerly not competent to undertake them, we further recommend that no such prosecution may be commenced without first obtaining the consent in writing of the Minister of Health to the contemplated prosecution. The discretion of the Minister can then be employed to ensure that prosecutions are undertaken only when the alleged contravention of the Act, or of any other scope-of-practice statute, appears to have been harmful to the public interest. Furthermore, the complaint by an interested discipline that the Minister was improperly refusing to consent may be made the subject of inquiry by the Health Commissioner.

Finally, we turn to another area of practice the satisfactory regulation of which is made difficult by the existence of a pluralistic system, and by professional attitudes towards advertising. One of the clearest deficiencies in our system of providing health care is that relating to entry by the patient to the system. When a person is in need of care on the first occasion after a lengthy period has passed during which he has not required curative attention, or when, for another example, he moves to a new community, he ought to have some alternative to the emergency department of a general hospital. He cannot, with the traditional ethical practices, hope to learn about the respective competences of the various members of the

[76]See p. 38.

[77]See Recommendation 309.

professions. If there is any source of advice in his community he is likely to be advised to consult the yellow pages. Resort to the telephone directory will yield no information about competence or, indeed, even readiness to accept new patients no matter what the competence. Much attention is devoted especially among the learned professions, by some of their best minds, to devising rules about the maximum sizes of the letters to be used on signs and directories. We think that a good case can be made for the position that professional ethics are too restrictive of the public's right to information about practitioners. Having recommended against a monolithic form of regulation, we have created an obstacle to a uniform and concerted reconsideration of the practices of advertising in the sense of informing the public about the nature and availability of services. It is our hope that all professions and occupational groups will give serious consideration to our criticism of the undesirable effects of traditional professional hostility to informing the public, and will devise a suitable plan for making useful information about practitioners available to members of the public. If they do not, thought will have to be given to enacting appropriate legislation entrusting this aspect of regulation to a central governmental agency. In our view, however, if responsibly used, this is a power which would be best left with the individual professions. But, to conclude as we began, it is essential that primacy be given to the public interest.

Recommendation:

334 That no prosecution for any alleged violation of section 51 of the Medical Act be undertaken unless the consent in writing of the Minister of Health has first been secured.

APPENDIX I TO CHAPTER 25
Financing of Regulatory Bodies

We were directed by section 1(b) of our terms of reference to inquire into "the method of raising and expending revenues" employed by the various regulatory and disciplinary bodies which have come under our purview. We have obtained the required information, some of which is synopsized in the accompanying tables.

In general, we have not found this to be a particularly contentious or troublesome area. We wish to make only the four following points.

First, we think it appropriate that a fee be charged to cover the costs of registration or licensing and internal discipline.

Second, we believe that the Province of Ontario, through the Department of Justice, should bear the cost of prosecutions of practitioners from outside the discipline concerned, who violate the statutes relevant to the discipline.

Third, the licensing or regulatory body should not collect fees for the "voluntary" associations. We have found only one discipline in which this is being done, and we understand that the practice is being discontinued, but we have made a Recommendation in this regard in Chapter 9.

Fourth, the "voluntary" associations should not be expected to bear the costs of major research undertakings initiated at the request of the Government of Ontario or its agencies, but such research should be financed from the public treasury.

TABLE 25.2

Total Revenue and Expenditures of Regulatory Bodies, 1965

Name of regulatory body	No. registered or licensed	Annual registration of licensing fee (dollars)	Total revenue (dollars)	Total expenditures (dollars)	Existing BALANCE at end of 1965 (dollars)
College of Physicians and Surgeons of Ontario	9,643	15	211,596	179,504	297,508
Royal College of Dental Surgeons of Ontario	2,514	125	246,211	229,951	415,196
College of Nurses of Ontario.	48,896	5	382,667	350,955	72,469
Ontario College of Pharmacy	4,309	20-50	290,371	267,278	175,290
Board of Directors of Chiropractic	605	30	13,095	15,128	3,917
Board of Regents of Chiropody	75	60	4,140	3,427	2,422
College of Optometrists of Ontario	533	100	137,552	144,808	121,361
Board of Directors of Osteopathy	74	25	2,146	2,636	4,976
Board of Directors of Physiotherapy	720	10	13,008	10,421	28,377
Ontario Board of Examiners in Psychology	369	100	6,060	3,657	5,700

SOURCE: Replies to Questionnaire "A" of the Committee on the Healing Arts.

TABLE 25.3

Breakdown of Revenue and Expenditure of Regulatory Bodies, Ontario, 1965

	REVENUE — IN DOLLARS			
Name of regulatory body	Fees	Interest on investments	Other	Total
College of Physicians and Surgeons of Ontario	186,274	13,966	Disciplinary costs recovered 6,050 Publications 3,719 Other 1,589	211,59
Royal College of Dental Surgeons of Ontario	212,442	7,105	Refunds 20,400 Property 4,692 Other 1,572	246,21
College of Nurses of Ontario (for year ending Aug. 31, 1965)	378,998		Donations 3,669	382,66
Ontario College of Pharmacy	279,598	7,296	Publications 1,402 Fines 900 Property 720 Other 455	290,37
College of Optometrists of Ontario (year ending May 31, 1966) (excl. Instruction Acct.)	47,262	4,853		52,11
Board of Directors of Chiropractic	12,872	223		13,09
Board of Directors of Physiotherapy	11,922	1,086		13,00
Ontario Board of Examiners in Psychology (for year ending April 30, 1965)	6,060			6,06
Board of Directors of Osteopathy of Ontario	1,880	266		2,14
Board of Regents, Chiropody Act, Ontario	4,140			4,14

[1]Includes registration, examinations and salaries.

[2]Includes attendance at conventions.

SOURCE: Replies to Questionnaire "A" of the Committee on the Healing Arts.

EXPENDITURE — IN DOLLARS							
Office dministra-tion[1]	Legal and auditing fees	Education[2]	Publica-tions and bulletins	Inspections and discipline	Other		Total
44,295	16,446	3,089	12,930	1,444	Public Relations Welfare	400 900	179,504
04,187	800	8,338	313	4,191	Grants	112,122	229,951
07,582	6,750	700		35,923			350,955
33,260	6,933	2,659	10,976	58,962	Grants Public Relations Scholarships	65,635 7,773 1,080	267,278
4,984	1,975	800	600		Bank charges and interest	950	9,309
13,886	825			417			15,128
9,396	769			256			10,421
3,232	425						3,657
1,786	850						2,636
1,054	2,000			373			3,427

APPENDIX II TO CHAPTER 25

Summary of Proposed Regulatory Arrangements for Health Practitioners and Facilities in the Healing Arts

Practitioners	Regulatory Body	Type of Regulation
Physicians	College of Physicians and Surgeons of Ontario	Licensing
Dentists	Royal College of Dental Surgeons of Ontario	Licensing
Dental hygienists	Health Disciplines Regulation Board	Licensing
Dental technicians	Health Disciplines Regulation Board	Certification
Nurses	College of Nurses of Ontario	Certification
Nursing assistants	Health Disciplines Regulation Board	Certification
Psychiatric nurses	College of Nurses of Ontario	Certification
Pharmacists	Ontario College of Pharmacy	Licensing
Pharmacy assistants	Health Disciplines Regulation Board	Certification
Optometrists	College of Optometrists of Ontario	Licensing
Ophthalmic dispensers	Health Disciplines Regulation Board	Licensing
Psychoanalysts (non-physicians)	Psychoanalysts Certification Board	Certification

Practitioners	Regulatory Body	Type of Regulation
Clinical psychologists	Clinical Psychologists Certification Board	Certification
Social workers	N/A	None
Child care workers	N/A	None
Chiropodists	Health Disciplines Regulation Board	Licensing
Physiotherapists	Health Disciplines Regulation Board	Licensing
Occupational therapists	Health Disciplines Regulation Board	Certification
Remedial gymnasts	Health Disciplines Regulation Board	Certification
Massage therapists	Health Disciplines Regulation Board	Licensing
Speech therapists	Health Disciplines Regulation Board	Certification
Audiologists	Health Disciplines Regulation Board	Certification
Hearing aid dispensers	Government agency not associated with health legislation	To be determined
Dietitians	N/A	None
Medical record librarians	Health Disciplines Regulation Board	Certification
Health technologists	Health Disciplines Regulation Board	Certification
Clinical chemists	N/A	None
Osteopaths	Health Disciplines Regulation Board	Licensing
Chiropractors	Regulation Board Health Disciplines	Licensing

Practitioners	Regulatory Body	Type of Regulation
Naturopaths	No separate body	Registration of existing naturopaths via an amendment to the Medical Act exempting them from the Medical Act.
Sectarian healers	N/A	None
Hypnosis technicians	Health Disciplines Regulation Board	Licensing
Facilities:		
Medical laboratories	Health Facilities Board	Licensing
Radiological facilities	Health Facilities Board	Licensing
Dental laboratories	Health Facilities Board	Licensing
Pharmacies	Health Facilities Board	Supervision of standards

Chapter 26 Education of Practitioners

It will be apparent from Volume 2 that although the Committee has approached its task pragmatically, a number of general principles underlie many of the specific recommendations, especially those having to do with matters of "regulation" and "education".

With regard to the education of health workers, the Committee believes most people would agree that ideally the system should be capable of satisfying individual demands for education, and that it should also be capable of preparing the required numbers of suitably qualified practitioners needed to provide the community with the health services it desires. We might also hope that the educational system could be flexible enough to adjust to changes in the kind of education young people entering the system want, and also to adjust to changes in the kinds and relative quantities of health services the community requires.

Because education is expensive, consuming as it does valuable resources the community could use to satisfy other needs, it may often be necessary to compromise and to satisfy one of these preferences instead of another. Owing to the costliness of some kinds of education, the capacity for educating students may be limited. Under these circumstances the importance of making the most efficient possible use of educational resources becomes self-evident.

The principles of adequacy, flexibility and efficiency in the education of health or any other kinds of workers are not always easy to reconcile with the exigencies of everyday administration. Nor are they always compatible with one another. Yet they do provide goals towards which those concerned with shaping education policy should always seek to work.

In this chapter, we outline the more serious shortcomings of the existing educational arrangements in the health field that appear when we examine them in the light of these general criteria. Our purpose here is to make explicit the thinking underlying the specific recommendations made on the subject of education in Volume 2.

The existing pattern of education for workers in the health services has evolved without benefit of overall planning or administration. While this is not in itself a fault, it does account for many of the problems that arise in this part of the educational system today: uncertainties about the appropriate locus of responsibilities for educating certain types of workers, instances of duplication of programs, inappropriate curricula, inconsistencies in admission requirements, and other specific difficulties of the kind noticed throughout the discussion of the

various health disciplines in Volume 2. It will be convenient for our purposes in this chapter to divide these problems into three main categories: 1) those relating to what kind and amount of education is required; 2) those having to do with who should determine and administer these requirements; and 3) those that have to do with how and where the required education is provided.

Kind and Amount of Education Required

In general, it appears to the Committee that the quantity and the quality of education being provided for most groups of health workers at present is adequate. Indeed, there is more reason to believe that some groups are being overeducated than that there are serious deficiencies in educational standards in any of the major health occupations. While individuals may benefit personally from prolonged formal education, it is far from clear that their ability to perform the work expected of them is materially diminished in its absence. It is admittedly very difficult to determine empirically whether a nurse, for example, is a better nurse for having a university degree. Because we have no standard measure of "productivity" for nurses, or any other health workers, we cannot directly relate their performance to their education. Furthermore, educational requirements and educational costs do restrict the flow of entrants to the health occupations. But it is not by chance that the highest paid health workers are those with the highest and most expensive educational qualifications. Whether or not such differentials in income can be socially justified is something our present information and available techniques of economic analysis do not permit us to judge. We can only indicate the need for more sustained research in this area, and hope that it may eventually show how we can achieve a more effective use of the resources we do commit to education.

Throughout our investigation of the educational requirements for the various health groups reported in Volume 2, the Committee has been conscious of a persistent tendency for these requirements to increase. An interest in raising educational qualifications has been conspicuous in the representations made to us by spokesmen for some of the newer occupations. Sometimes a case could be made for raising qualifications to accommodate changes in technology or changes in the role of the occupational group concerned. Again, such a suspicion is difficult to validate empirically. But sometimes, too, it was difficult to avoid the suspicion that these proposals could be attributed to the measures of prestige and exclusiveness higher educational attainments were expected to confer upon the members of the occupation concerned. Nevertheless, the possibility that this kind of pressure exists is strong enough to lead the Committee to urge that those responsible for approving changes, especially increases, in educational requirements for these groups, should be expected to show good reasons for them and be able to convince "outsiders" of the value of such changes.

Apart from this apprehension that educational requirements for some groups of health workers may now be or may become excessive, the Committee's concern

with the kind and amount of education presently being provided for these groups is that it neglects certain aspects of health care — notably by emphasizing acute curative work to the virtual exclusion, in some cases, of preventive and social aspects of health care. Existing programs also seem to pay too little attention to how different kinds of health workers can be helped to work together in providing the kind of health services expected by the community today.

The Committee believes that the education of physicians, dentists, nurses, paramedical personnel and other health workers should attempt explicitly to convey more than a token understanding of the social and preventive aspects of their work, and that it should also equip them to coordinate their activities with those of other health workers. From what we have learned of the existing educational programs operating in the health field, it appears that progress towards developing the spirit and techniques of such cooperation has been perceptible, but slow. The Committee believes that one important reason for this is the lack of substantial knowledge concerning the effectiveness of various alternative methods for organizing health services and for combining preventive with curative functions. We have elsewhere in our Report (see Chapter 29) referred to the need for more research into the possibilities of devising alternative patterns for organizing the provision of health care. Much of this work will appropriately fall to the faculty and staff of educational institutions who will simultaneously be responsible for communicating it to their students.

Our third general observation about the content of health education programs has to do with the problem of determining the appropriate balance between what might be called "general" and "practical" elements in these programs. Here we are handicapped by not being certain whether such a distinction is worth making. That such a distinction is at least conceivable is evident from some of the issues alluded to in Volume 2. The general issue which has arisen there may be stated thus: should the formal education required of physicians, dentists, nurses and other occupational groups be comprehensive, in the sense that it qualifies the graduate for immediate practice, or should this formal education merely prepare a person to *become* a physician, dentist or nurse? At another level, should a dental technician's education be such that he can do the job of a dental technician upon graduation, or should he merely acquire the background in general "academic" subjects that he requires in order to go on to master through practical work the routine skills of his trade?

The historical tendency in this regard seems to have been for those determining educational policy in the health field to work towards packing both practical and academic work into the same educational program. Sometimes, as in the case of dentistry, this has meant taking the workbench into the classroom. In other cases, notably medicine and nursing, it has meant making a classroom out of the workshop. This intermingling of academic and practical work training has many consequences, and reference to some of them will be made again later in this chapter when we consider the questions of who should control the education of health

personnel and at what institutions this education should be provided. Here we are concerned only with the issues it gives rise to in terms of the quantity and quality of the educational requirements for these disciplines.

Although we have not sought in the Report to make detailed recommendations concerning the academic and practical education required for specific groups of health workers, we have become conscious of the dangers inherent in treating formal education requirements for these groups as being comprehensive and "complete" experiences, sufficient to provide the worker with all he will subsequently have to know in order to do his job. The rapid obsolescence of knowledge in the field of health care makes such a view of education not only inappropriate but dangerous.

Various kinds of learning will have to be part of many professional and technical educational programs in the future. Less and less will it be possible to think of educational programs as means of acquiring once and for all sufficient preparation for practice. Yet this approach to education will not be quickly accepted by everyone; for the idea of a comprehensive, complete education is still embedded in the minds of many of our professional workers and even in the thinking of some of our educators. Therefore, the Committee attaches much importance to the recommendations it has made concerning continuing education programs for the major health professions with which we have been concerned. (See Chapter 25, Recommendations 321, 322, 323.)

It will be noted that our recommendations go beyond the usual pious affirmations of the value of continuing education commonplace in discussions on this subject. On the other hand, we do not adopt one of the alternatives proposed in the United States by the *Report of the National Advisory Commission on Health Manpower* (the Miller Commission) that physicians, for example, should necessarily be obliged to sit periodic re-examinations as a necessary condition of relicensure.[1] We recognize that the long-run solution to this problem lies in the genuine acceptance by practitioners of the view that the education they require cannot be completed before entering practice. We urge that the authorities responsible for devising the education to be provided during the preparatory period view their task as enabling their students not to be "finished products" upon graduation, but to be persons equipped and motivated to keep abreast of, and ideally to advance by their own work, the knowledge of their discipline.

We are persuaded that for the major health disciplines, continuing education should be made a condition of the right to continue to practise, but that the forms of continuing education should be flexible and adapted to the needs of the various professions and the individual practitioners. The purpose of continuing education is to assure the public that practitioners maintain high levels of professional competence, and with this purpose there can be no quarrel.

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[1] *Report of the National Advisory Commission on Health Manpower*, Vol. I, United States Government Printing Office, Washington, D.C., 1967, pp. 42 and 80.

As to who these authorities responsible for devising educational programs should be, for reasons explained in the following section, the Committee favours placing responsibility for education in the hands of educational bodies which are the best qualified to perform this task. In the area of continuing education for the major health professions, we hold to this same view. We have proposed, in the chapters devoted to these professions, that the educational institutions initially responsible for training health practitioners should also assume responsibility for developing and maintaining appropriate programs through which their graduates can refresh and further develop their knowledge and skills. In this way the coordination of continuing education and the initial education can be readily ensured. Furthermore, it is these educational institutions which are most likely to keep abreast of the developments in the professional disciplines concerned, and to be most highly oriented towards change as opposed to the preservation of the status quo in these disciplines. We wish to emphasize that, if continuing education is to be effective, it must be flexible and readily adaptable not only to the specific needs of particular professions, but also to changes in these needs as they occur over time.

Thus we have thought it neither possible nor desirable to try to establish any one general pattern for continuing education programs. The relevant educational institutions must be free to develop the means of continuing education most appropriate to their discipline. It is understood that there are different combinations of formal and informal course work, research activities, and teaching functions that may be appropriate to ensure the continued competence of practitioners in different professions, and even of individual practitioners within a particular profession.

Therefore, we propose that practitioners of the major health disciplines should be required periodically to demonstrate some evidence of their continuing competence to the appropriate educational authority. That educational authority, in turn, should advise the licensing body whether individual practitioners have maintained their competence and should remain eligible for continued licensure. Since the implementation of these educational programs will prove costly and impose new financial burdens upon universities, and since we do not think it desirable that practitioners should bear these costs, substantial amounts of public funds will have to be allocated to educational institutions for this purpose.

Control of Education

The process of determining educational policy for the groups we are concerned with involves a number of interested parties: the individuals who receive the education, the members of organized occupational groups into which they may eventually be accepted as colleagues, the institutions that will eventually employ them, the educational authorities who will prepare them, and the government bodies that will be held responsible for meeting the needs of the community for educational opportunities and health manpower.

The individual interest in education as a "consumer" good is direct, but until recently those being educated have not been effectively organized for the purpose of influencing educational policy. Students have not had much to say about admission requirements, curricula, and other major parts of educational policy, especially in the "professionally oriented programs" for many types of health workers. Recently, however, students have shown increasing interest in participating in the formation of policies affecting their education, but it is too soon to assess the effects student participation may have on the aspects of educational policy we are concerned with here.

The second group directly interested in educational policy for health workers is made up of members of the various health occupations themselves. One of the characteristics of these occupations is the extent to which they retain, or in the cases of the newer ones seem intent upon developing, a guild-like organization, a principal function of which is to promote the interest of the group. Sometimes, as with the physicians, dentists and pharmacists, the professional voluntary body has been supplemented by a professional "college" formally entrusted with responsibility for regulating the practice concerned and for establishing educational standards. The logic underlying these arrangements appears to have rested upon the practical assumption that because practitioners in these fields were the only persons in the community to possess the specialized knowledge and skills involved, only they could determine what and how students seeking to qualify for practice should be taught. But as the amount and variety of knowledge in these fields increased, it became more and more difficult for practitioners as such to remain "authorities" in their own fields. As shown in the historical accounts set out elsewhere in our Report, education in the senior health professions has tended to move out of institutions operated or controlled by the practitioners themselves and into the university faculties. In the case of the paramedical and other "technical" groups, responsibility for education has tended to move from those operating special training schools or apprenticeship programs to general educational authorities. Along with this, control over admission requirements, curriculum content and examinations have shifted from the professional organization to the schools, from the rank-and-file practitioners to practitioners with university appointments and to full-time academics.

This process is far from complete today. Indeed, we must expect it to accelerate, for the forces behind it, notably the accumulation of scientific knowledge relevant to the practice of these professions, are becoming more and more powerful.

The Committee recognizes that there could be dangers associated with this loss of control over education by the professional groups. The general membership of a profession may be poorly equipped to understand the specialized and more sophisticated knowledge upon which their work is, or should be, based. But they are in touch with the day-to-day work students may find themselves doing after graduation. It is possible that academicians may err in determining

curricula, for example, by placing too much emphasis on the arcane and esoteric. Or they may apply admission requirements that select students more for their promise in coping with "science" than their ability to work effectively with sick people. If not offset, such proclivities could interfere with the efficiency of the education of health care workers, and educational resources might be used to produce inappropriately prepared graduates.

Yet the Committee has also recognized that valid reasons have existed for this shift of control from practising professionals to educational authorities in the past, and it has been reluctant to propose any measures which would obstruct this trend in the future. The desirability of promoting rapid technological change in the health fields, and of having new knowledge and approaches to the provision of health care expeditiously embodied in the education of students, are considerations that go far towards justifying the location of control over the education of health workers in bodies more closely associated with education, research and health planning. This trend is not confined to the health field; for it is part of a larger trend in our evolution as an advanced industrial society that began in England late in the eighteenth century, when the right of the guilds to control education in many of the traditional occupations was abrogated to accommodate the needs of the emerging industrial system. Public support for this has been stimulated by the fear that professional control of education would be used as a means of protecting established occupational interests by limiting numbers and by resisting any changes that threatened to make obsolete the skills of established members of the occupation. Today there should be no room for any suspicion on the part of the public that such restrictive practices are available to professional groups in a field as vital to the public welfare as health.

To the extent that removing direct control of education from the professional groups concerned may lead to a risk that the educational authorities could produce the wrong sort of practitioners, the Committee believes that adequate safeguards exist to reveal and to correct any such faults to which the proposed system may be subject.

In the case of medicine, for example, we have seen that one of the ways of ensuring that the education provided by the medical schools is appropriate is provided through the system for accrediting these schools; another is by means of the Medical Council of Canada examinations; and yet another is by the work of the Association of Canadian Medical Colleges. To these formal controls may be added a number of spontaneous controls—among them, the self-interest of students and faculty which will cause them to shun a school that provides a poor professional preparation. Hospitals would, we know, be reluctant to take on staff graduates of schools with bad reputations, and in professional circles such reputations become known very rapidly. The faculty of professional schools, too, would provide a further line of defence against the introduction of inappropriate kinds of training. Far from being isolated in ivory towers, the members of professional faculties often are closely associated with outside professional bodies. We have

seen, too, that many of them are practitioners as well as teachers, and as such are directly in touch with current standards of practice at the most sophisticated levels.

The majority of the Committee is convinced that control of education for health workers should be exercised by educational rather than professional bodies as such.* Thus, in the case of the major health professions — medicine, dentistry and pharmacy—determination of admission requirements, curriculum and examinations is seen as being primarily the responsibility of the medical, dental and pharmacy faculties in the universities and of the various accrediting and other bodies associated with them. In the other occupations, those that are educated in Colleges of Applied Arts and Technology (see below) and in specialized institutions will be subject to the control of the bodies responsible for these parts of the province's overall educational system, with appropriate channels for advice concerning manpower requirements, course length and curriculum being established to link the Ontario Council of Health to these policy-making bodies in the field of education. The Committee's conception of these relationships will be set out more fully in the following section where the matter of the appropriate location of these various health education facilities is discussed.

Location of Educational Programs

Facilities for educating health care workers are presently provided in universities, in Colleges of Applied Arts and Technology, in hospital schools, in specialized regional schools for preparing medical technologists and nurses, in vocational courses offered in the secondary school system, and in a few specialized institutions run by professional organizations.

This can hardly be described as a system of health care education, for it has no formal structure linking together these various institutions, courses and programs. However, interest in devising such a formal structure appears to have arisen in recent decades in the hope of facilitating manpower planning in the health field, and also in the expectation that the education of health workers could thereby be improved. The Committee shares these interests and expectations, but is not persuaded that devising a comprehensive formal health education system can or should be the principal objective of public policy in this field. If only the manpower planning aspects of education were involved here, this reservation might not have to be introduced. But throughout our study of the various occupational groups in Volume 2, the Committee has regarded the education of health workers as being properly part of an education experience as well as part of society's manpower training processes. Because of this the Committee has emphasized the desirability of fitting health education programs into the rest of the general educational system, rather than taking them out and organizing them as a distinct educational subsystem. This does not mean that the Committee thinks

*See minority opinion, pp. 220-225.

opportunities to rationalize the organization of health workers should be ignored; for there may be benefits to be derived from some reorganization, and particularly from some greater coordination of certain educational programs and facilities. It is possible that by gathering certain groups together for their education, the ability of these groups to work efficiently and harmoniously together in subsequent employment could be improved. It is also possible that economies could be realized if such a consolidation of health education programs permitted more efficient use of administrators, faculty and other personnel, as well as of buildings, equipment and clinical resources.

These possibilities have been explored most fully in connection with the idea of the health or medical sciences centres being developed in a number of universities. Although these may also sometimes incorporate programs for educating non-degree level workers, in Ontario the establishment of Colleges of Applied Arts and Technology appears to be providing a more suitable kind of institution around which the non-degree programs are beginning to coalesce. We will consider these two focal points for the education of health workers in turn.

University Health Science Centres

A number of universities, most of them in the United States, have undertaken to integrate the teaching of related health science disciplines. The main purposes of this movement appear to have been to reduce administrative costs and personnel requirements; to facilitate utilization of the expensive "core" facilities required for clinical training; to make more efficient use of scarce teaching faculty; to facilitate the development of new programs, and the expansion or modification of existing programs; to encourage interdisciplinary teaching and research; and to promote the "health team" approach to the organization of health care. These integrated teaching programs have taken a number of different forms. In some instances the health sciences program has been little more than a loose association of medical, dental, nursing, and other faculties or schools of the university. In others, a much more closely knit organization has been developed, with the traditional faculties and schools submerged in it.

In Canada, the concept of the health science centre began to attract attention in the early 1960's. Formal planning to establish several of these centres began after the Health Resources Fund was established by the federal government in response to the recommendations of the Royal Commission on Health Services. In Ontario, "health sciences centres" now exist or are being planned at all the medical schools in Ontario.

A Vice-president, Health Sciences, was appointed at the University of Toronto in 1966 in recognition that all disciplines concerned with health care in the university had a common interest in the basic health sciences and in clinical training. The integration of the university's health sciences has been facilitated by construction of a thirty-five million dollar medical sciences building in which students of

all disciplines of health care will study together. Construction of the building began in June, 1966 and was completed in the fall of 1969. The building has been designed to be used by 500 students in medicine, 400 in dentisty, 250 in pharmacy, and 100 in nursing. Full-time staff are expected to number about 400.

The University of Ottawa is planning a health sciences centre, and it is expected that almost fifty million dollars will eventually be required for construction, renovation, acquisition and equipping of the facilities that will be part of this project when completed.

At Queen's University a seventeen million dollar health sciences centre is planned. It will bring all departments in the faculty of medicine and the associated schools and departments together. Facilities for the education of physicians, nurses, and ancillary occupational groups will be centralized to emphasize the interdependence of the "health team". There are plans to develop a common basic science course in anatomy, physiology and biochemistry. The centre will be used by physicians and related professions in their degree and diploma courses. Queen's has also recently opened a new School of Rehabilitation Medicine, consisting of the School of Rehabilitation Therapy and the Kingston General Hospital's Regional Rehabilitation Centre, as part of the health sciences centre project.

McMaster University is participating in development of the new Hamilton medical complex being built to house the College of Health Sciences, a 410-bed teaching hospital, and expanded school of nursing, and the new Faculty of Medicine, which has enrolled its first students. According to present plans, medical social workers, clinical psychologists, physical and occupational therapists, will be enrolled in 1970-1971. Faculties of dentistry and pharmacy will be added, if required, at the second stage in 1975-1980.

The University of Western Ontario is rapidly expanding its School of Health Sciences. In addition to medicine and nursing, a Faculty of Dentistry enrolled its first students in 1966, and a four-year degree program in physiotherapy also commenced in that year. Future plans include the establishment of a Bachelor of Science in Medical Rehabilitation (B.Sc.M.R.) program in speech pathology and audiology, in 1971; a B.Sc.M.R. program in occupational therapy, a four-year honours degree program in dental hygiene, an M.Clin.Dent. degree program in oral surgery, orthodontics, paedodontics and periodontics, and a Master's degree program in clinical nursing in 1971-1972. By 1973-1974 the university plans to introduce both B.Sc. and M.Sc. degree programs in health administration.[2]

Attached to Western's School of Health Sciences is a Family Medical Centre, which began in St. Joseph's Hospital in 1966 and moved to a new building outside the hospital in November 1969. The Family Medical Centre, operated jointly by St. Joseph's Hospital and the university, has a three-fold purpose: to train medical graduates as specialists in family medicine, to provide personal family

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[2]*The University of Western Ontario News*, Vol. 5, No. 16, November 20, 1969.

medical care to the community, and to conduct research into the delivery of health care.[3]

Outside Ontario, large health sciences centres are being developed at Dalhousie University, the University of British Columbia and the University of Alberta. Dalhousie University established a Faculty of Health Professions in 1961, making Dalhousie one of the first universities in Canada to consolidate training programs for health personnel. This faculty now consists of a School of Nursing, giving a four-year degree course; a College of Pharmacy; a School of Physiotherapy, offering a two-year diploma course; and a School of Physical Education, offering a four-year degree course. A school of occupational therapy and a medical library science degree course are also being planned. The Dalhousie School of Dental Hygiene is under the Faculty of Dentistry, but students take courses in anatomy, physiology and microbiology along with other students in the Faculty of Health Professions. Programs in clinical psychology, social work, speech therapy and audiology are not provided at present, but Dalhousie has accepted responsibility for training personnel in these fields when it becomes possible to do so.

Planning began in 1963 for the University of British Columbia's health sciences centre which is expected to accommodate dentistry and basic sciences facilities, an ophthalmology research and training unit, a psychiatric and neurological unit, a 120-bed hospital, and research facilities to be used by students in medicine, psychology, nursing, medical social work and rehabilitation therapy.

At the University of Alberta, Calgary campus, a new health sciences centre, expected to cost eighty-eight million dollars, is being built over a period of eight years. It will be one of the world's most advanced medical complexes when completed. It is to consist of a Faculty of Medicine, the Western Canada Cardiology Institute, a neurological centre, the Faculty of Dentistry, a clinical sciences building, the pathology and bacteriology faculty, a school of basic medical sciences, a building for ambulatory patients, and a central medical library.

These developments have not yet gone far enough to reveal a common pattern for the organization of health sciences centres. It seems that in those developed to date, most of the emphasis has been upon the sharing of administration, faculty, space and clinical resources, much more than upon the development of a common "core curriculum" for students in various disciplines. Considerable interest has been shown, however, in the possibility of organizing instruction in health sciences centres, so that students in various disciplines might take certain common courses. Some new curricula for medical students, which provide them with their basic medical and social science courses in the first two or three years of their undergraduate program, may make it possible for them to take some of these classes with students from other health related professions.

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[3]*The University of Western Ontario News,* Vol. 5, No. 17, November 27, 1969.

The medical program at the University of Illinois in the United States, at Nottingham in the United Kingdom, and at McMaster in Hamilton, Ontario exemplify this.

In each of these three programs, the medical student is required to have completed a phase of preclinical education at the end of which a baccalaureate degree is awarded. The medical program at the University of Illinois covers a period of seven years after high school, the first three years of which are spent earning a Bachelor of Science (Medicine). The new medical school at Nottingham in the United Kingdom offers a five-year (plus two years preregistration internship) program, the first three years of which is an initial phase of preclinical education in human biology. These three years are equivalent to a degree course at the end of which a Bachelor of Science is awarded. At McMaster, the admission prerequisite for the Faculty of Medicine is a baccalaureate degree or three years of an honours program in McMaster's Faculty of Arts and Sciences, with knowledge of biology and biochemistry. This means that future medical students and students who intend to go into other health related professions would have shared some courses together at the undergraduate level before they go into their separate specialties.

When it comes to sharing courses at higher or more specialized levels than this, however, difficult problems arise. One is that the same subject may have to be taught in different ways to meet the needs of students being prepared to work in different fields. The University of Florida has found, for example, that the anatomy course required by physiotherapists is not the same as that needed by occupational therapists. Devising ways to organize various university departments, faculties and schools, so that the core curriculum would meet these specific requirements of the various occupational groups involved, appears to be a formidable task, even when the students being prepared have the same minimum educational qualifications and potential. When we consider the problems of incorporating the education of health workers with different educational backgrounds, it is apparent that a strong a priori case can be made for establishing a second level at which coordination could be attempted. In Ontario, this appears to have been made possible by the establishment of the Colleges of Applied Arts and Technology.

One possible objection to relying upon another point of focus such as this could be that it defeats the object of bringing future members of the "health team" together for at least part of their training. Another is that it may create a barrier preventing able students from moving to a higher level of competence once they are streamed into a college instead of a university program. The first objection is probably outweighed by the difficulties, already remarked upon, of developing core programs at the university level; these difficulties would be compounded by attempting to teach the same subjects in the same way to students with very different levels of educational background. The second may at least be minimized by providing for transfer between Colleges of Applied Arts and Tech-

nology and university programs. The Committee believes that provincial education authorities should give further attention to devising ways of facilitating the transfer of appropriate students from Colleges of Applied Arts and Technology to universities, and also in the opposite direction as well. Not all students who begin a university program are suited to it; some who are not might well find a satisfying alternative in a College of Applied Arts and Technology program if they could transfer to it without loss of credit for the time spent at the university.

College of Applied Arts and Technology Programs

Most paramedical personnel traditionally have been trained on the job, in programs organized by the hospitals, or in diploma or certificate courses sponsored by universities. We have seen, however, that recent advances in the medical sciences have resulted in the introduction of sophisticated and complex medical instrumentation systems and the emergence of new paramedical specialties. The on-the-job training concept is not well suited to preparing workers along these lines. Much of the growing amount of knowledge required can be provided efficiently only by means of professional, didactic instruction. Training programs organized by hospitals to provide such instruction have the advantage of being closely allied to service needs, but the disadvantage of being oriented towards filling the immediate needs of individual hospitals. Hospitals that are too small to operate training programs of their own have often had difficulty obtaining the workers they require. The larger ones sponsoring such training programs have complained of financing and staffing problems connected with them, and these difficulties have been only partly overcome by pooling arrangements among individual hospitals. University certificate and diploma programs in health fields have been limited in number, and we have seen that universities appear to be reluctant to expand these offerings. Even those universities developing health sciences centres seem generally uninterested in introducing anything but degree courses for paramedical workers. In the report on the health sciences in Ontario universities, the Presidents' Research Committee to the Committee of Presidents of Universities of Ontario, has suggested that universities should be released from the responsibility of training paramedical personnel and that the primary responsibility for this should be assumed by the Colleges of Applied Arts and Technology.[4] The Committee concurs with this general position; although, for reasons which will be made explicit below, it does not anticipate any sudden transfer of all paramedical training programs to these new institutions.

The Ontario system of Colleges of Applied Arts and Technology was established under the provisions of an amendment to the Department of Education Act in 1965. The introduction of a network of such Colleges throughout the province was designed specifically to overcome a perceived deficiency in our educational system in regard to the training of technical personnel beyond the high school but

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[4]Committee of Presidents of Universities of Ontario, *The Health Sciences in Ontario Universities,* University of Toronto Press, Toronto, 1967, p. 4.

short of the university level. The new Colleges were expected to provide a wide range of education, both vocational and avocational, and to meet the particular needs of the geographic areas within which they were located.

Each College of Applied Arts and Technology is under the control of a local board of governors, which has a large degree of autonomy so as to permit adaptation of the college's programs to local needs and conditions. The board of governors appoints the chief administrative officer of the college and all other teaching and non-teaching personnel and establishes an operating budget annually.

A Council of Regents, composed of fifteen members, is appointed by the Minister of Education. It recommends to the Minister of Education the appointment of members to the board of governors of each of the colleges, coordinates the work of these local boards and advises the Minister of Education on all matters concerning the colleges. The Department of Education's responsibilities in connection with the colleges are administered by the Applied Arts and Technology Branch of the Department. This branch assesses the operating budgets of the local boards and, to the degree necessary, coordinates the curricula of the colleges. It works in close association with the Council of Regents.

The board of governors is assisted at the local level by a number of advisory committees. One of the functions of these advisory committees is to provide communication between the college and local industry, business and relevant public agencies.

The colleges derive their revenue from the provincial treasury on the basis of an annual operating budget and from student fees. Students are eligible for Ontario Student Awards and Canada Student Loans.

Colleges of Applied Arts and Technology are located in twenty areas of the province which roughly coincide with the economic regions used by the Ontario Department of Trade and Development. Because of the varying population densities in various parts of Ontario, some colleges have more than one campus. Northern College located in Timmins, for example, has three subsidiary campuses located in South Porcupine, Kirkland Lake and Haileybury, each of which may operate separate and different programs. Each board of governors is responsible for establishing college locations in its own area, subject to approval by the Council of Regents. There are presently thirty such campuses. It appears that this regional organization is primarily intended for purposes of administration, since students living in one area are permitted to attend the college in another area. It should be noted that one college, Ryerson Polytechnical Institute, belongs to this system but differs in that it was the institution which pioneered vocational education at the technological and applied arts level in this province. Ryerson has operated as an independent organization since 1964 when the Ryerson Polytechnical Institute Act was passed.

Each College of Applied Arts and Technology consists of three divisions: technology, business and applied arts. A wide range of courses is provided in

each division, including courses of one to three years' duration, short courses and refresher courses.

Specific admission requirements vary for different courses and programs offered in the colleges, but the general requirements are grade twelve of the five-year secondary school program — or, in some cases, an average of 70 per cent in grade twelve of a four-year program for admission to the three-year college courses; any grade twelve diploma for most of the two-year or shorter programs. A mature students provision enables persons nineteen years of age or older who lack the required qualifications to enter certain courses and to obtain instruction in upgrading classes as required.

The number of programs being offered in the health sciences in the Colleges of Applied Arts and Technology is increasing as the organization and construction of these colleges proceed. At the time of writing, 1969, three-year courses were being offered in medical laboratory technology and in nursing programs; two-year courses to prepare medical secretaries, child care workers, food supervisors and technicians, prosthetic technicians, public health inspectors, social services technicians, welfare institution managers, welfare services staff, dental technicians, inhalation therapy technicians, laboratory technicians, x-ray technicians and medical electronics technicians; one-year courses for medical secretaries and public health inspectors; and special shorter programs for ophthalmic assistants and for radiological technicians which provide part of the academic portion of the training required by such personnel.[5]

Because the Colleges of Applied Arts and Technology are in such an early stage of their development, there are many aspects of their potential for training paramedicals in courses such as these that cannot yet be assessed. However, some of the experience to date indicates that with proper planning, highly successful programs for preparing health workers can be established in this system. One of the most encouraging developments is in the field of medical laboratory technology.

The first program in medical laboratory technology was established at Algonquin College in Ottawa. This program was made possible through the coordinated efforts of the Canadian Association of Pathologists, the Canadian Association of Medical Bacteriologists, the Canadian Society of Clinical Chemists, the Canadian Medical Association, the Ontario Hospital Association, the Ontario Hospital Services Commission, the Ontario Department of Education, and the Canadian Society of Laboratory Technologists. Thus, the program has been planned by all the groups interested in the preparation of medical technologists: the hospitals providing the clinical facilities for the practical portion of training; the professional groups whose members are the future supervisors of graduates of the program; the Canadian Society of Laboratory Technologists, which constitutes the voluntary association future graduates will join; and the future employers of these graduates.

[5]See Chapter 6, Table 54 for complete listing of such programs in Colleges of Applied Arts and Technology.

Colleges interested in developing medical laboratory programs can now follow the Algonquin precedent. In January 1968, the Council of Regents of Ontario's Colleges of Applied Arts and Technology issued a statement of guidance to chairmen of the boards of governors and to presidents of Colleges of Applied Arts and Technology regarding the establishing of courses in medical laboratory technology and courses for medical laboratory assistants.

This experience has demonstrated that if the machinery for determining requirements and standards can be worked out, what appear to be highly satisfactory training programs can be provided in the Colleges of Applied Arts and Technology system. But much work must be done by the colleges and by the many other interested bodies involved if the colleges are to take up the primary responsibility for training paramedical personnel on the scale envisioned by the Presidents' Research Committee on Health Sciences in Ontario Universities.

While the theoretical portions of instruction of applied courses are given in the colleges, the clinical portion and practical experience will have to be provided in hospitals and other service institutions. Close cooperation between the colleges and the service institutions will be necessary to ensure the availability of equipment and space for training purposes. It will also be important to ensure, on the one hand, that the trainees will not be used as cheap labour by hospitals, and on the other hand, that the academic portion of instruction given by the colleges will not be too far removed from the reality of what the future graduate will be doing in the hospitals. The Committee notes in this respect that the American Hospital Association[6] has stated that the hospital has an important role and responsibility in providing clinical facilities for a collaborative educational program in health care fields. We have not attempted to define such a policy for Ontario, but the Committee believes that the educational institution and not the hospital should be responsible for the surveillance of such programs.

The other interested parties involved in the preparation of health workers in the Colleges of Applied Arts and Technology are physicians, professional social workers, and other groups which will utilize or supervise graduates of College of Applied Arts and Technology programs. The cooperation of these groups is necessary, not only in an advisory capacity when standards are being established, but also in making known the competence of these supporting personnel so that they can be properly utilized and enabled to function satisfactorily as members of the health team. There could otherwise be a danger of teaching skills in the college programs which may not be readily marketable or acceptable to professional groups. An example of what can happen in this regard is provided by the experience of some welfare services technicians. Although there is a need for social workers trained below the Master of Social Work level, some employing agencies have been unwilling to take graduates of College of Applied Arts and Technology

[6] *A Guide for Health Technology Program Planning,* National Health Council, New York, 1967, Appendix E, p. 50.

two-year courses whom they consider to be too young, at the age of nineteen, to handle problems which may be of a rather delicate emotional nature. Furthermore, as this is a relatively new category of personnel in the field of social work, administrators have been uncertain as to what the skills and performance of these new graduates may be and what kind of work they should be entrusted with.

There already exist established standards regarding entrance requirements, duration of training, course content, and qualifications for registration or certification maintained by national or provincial voluntary associations for many of the paramedical personnel which will be or are being trained in Colleges of Applied Arts and Technology. The Committee recommended in Chapter 25 that regulation of most of these groups be undertaken by the proposed Health Disciplines Regulation Board through its Divisions responsible for developing regulatory standards and requirements for each group. Close cooperation will be required between Colleges of Applied Arts and Technology and this Board and its Divisions to ensure that the educational programs provided by the Colleges are acceptable to regulating agencies. For example, the stated basic principle in the establishment of Colleges of Applied Arts and Technology was that they should provide a wide range of education regardless of formal entrance requirements. The existing registration boards of these groups, however, may impose academic requirements that must be fulfilled before a person is eligible for registration. The usual grade twelve prerequisite for admission into a College of Applied Arts and Technology course, for example, is lower than the minimum (grade thirteen) presently required by the Canadian Society of Laboratory Technologists. Control of educational standards and entrance requirements was considered in Chapter 25; here we need only note that the Committee does not foresee all health groups being educated in university or college programs. For some groups the training will remain relatively short and the entrance requirements even less than grade twelve; in these cases education might more appropriately take place in institutions other than Colleges of Applied Arts and Technology. Examples of such personnel would be chairside dental assistants, orderlies and nurse's aides.

As the traditional apprenticeship approach to the training of paramedical personnel is being replaced by this more systematic one with formal didactic courses given in Colleges of Applied Arts and Technology or specialized institutes of the kind referred to above, it is now possible to consider the introduction of core curricula into these programs. However, the same problems encountered by universities in their attempt to introduce core curricula into the programs of the health sciences centres also arise here. Many of the difficulties associated with developing such core programs at the college level are discussed in the brief submitted to the Committee on the Healing Arts by the Planning Committee for the proposed Toronto Institute for Training in the Technological Aspects of Laboratory Medicine. This brief discusses the question of whether any aspect of the cur-

riculum for medical technologists can be shared with other paramedical disciplines, such as x-ray technologists or physiotherapists. The brief contends that:

> The specific or professional portion of the courses are so widely divergent that no useful fusion can be seen in this part of the curriculum. The only possible common ground exists in what might be termed the general knowledge portion of the course. This implies anatomy, physiology, physics, chemistry and possibly mathematics.
>
> But even in these areas, the basic requirements are different, e.g. a general R.T. (registered laboratory technologist) would require to know little, if any detailed skeletal anatomy, while x-ray technologists presumably would require more detail. This is true of virtually all aspects of the respective training programs.[7]

The brief goes on to emphasize that unless all paramedical disciplines were able to define clearly their training requirements and qualifications (as the Planning Committee has done for medical laboratory technologists), it would not be possible to assess the degree of integration possible among the disciplines.

The need for research into these possibilities and for careful planning for improving the education of health workers has been emphasized elsewhere in our Report (see Chapter 24). If it is to be effective, a well-coordinated system must be created for gathering information and for recommending policies to the educational authorities which the Committee sees as being mainly responsible for their actual implementation.

Administration and Planning of Health Education Programs

The organization of health education envisioned by the Committee would have the effect of placing nearly all health education in the hands of educational authorities. Thus, to the extent that government policy should influence the education of health workers, the principal responsibility would rest with the Department of Education and the Department of University Affairs. At the same time, the Committee wishes to stress the importance of devising means whereby the Department of Health could make known to these educational authorities its manpower planning requirements before acute problems of manpower shortages could occur. Thus the Committee proposes that the provincial Cabinet should be assisted in determining policies affecting the education of health workers by a Coordinating Committee of the Cabinet on Health Education. This body would consist of the Ministers of Education, University Affairs, and Health. It would probably be desirable for this committee to have a full-time secretary who would be responsible for seeing that relevant items were placed on the agenda of the Cabinet Committee.

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[7]Toronto Institute for Training in the Technological Aspects of Laboratory Medicine, Brief to the Committee on the Healing Arts, 1967, p. 6.

The Cabinet Coordinating Committee for health education would in turn be assisted by a subcommittee similar in its organization to the existing Senior Coordinating Committee of Deputy Ministers. This Senior Coordinating Committee would consist of the Deputy Ministers for Education, University Affairs, and Health.

The Department of Education should be responsible for the general supervision and financing of the boards operating regional schools of nursing and the boards of governors of the Colleges of Applied Arts and Technology. Administration of the latter by the Department of Education would be effected through the existing channels connecting the Department through the Council of Regents to the boards of governors of the Colleges of Applied Arts and Technology. The Department would be assisted in this work by the educational advisory committees established for those groups of health workers who are educated in the regional schools of nursing and in the Colleges of Applied Arts and Technology. These educational advisory committees for the various disciplines would be so constituted as to give representation to the various disciplines themselves, related disciplines, practitioners from the disciplines (not the representatives of interest groups such as colleges of practice or voluntary associations), and lay representatives, both male and female.

The functions of the Education Advisory Committees would be to advise the Minister of Education on curriculum, length of program, and all other relevant aspects of the education required by the discipline concerned. All appointees to these committees should be selected by the Lieutenant Governor in Council on personal merit and not primarily as representatives of interested groups, although, of course, it is not intended by this qualification that members of the executives of voluntary associations or of the councils of regulatory bodies concerned are disqualified for membership.

The existing arrangements between the Department of University Affairs and boards of governors of the universities of Ontario should remain much as they are at present.

The Department of Health should no longer be responsible for operating educational programs, with the possible exception of registered nursing assistants' training programs and any others which it is not immediately feasible to transfer to the Colleges of Applied Arts and Technology or other institutions operated by the Department of Education. The Department of Health would be advised concerning manpower requirements in the various health disciplines by its own research branch and by the Ontario Council of Health.

Finally, the Department of Social and Family Services would participate with the Departments of Education, University Affairs, and Health in the formulation of policy affecting the training of social workers and social work assistants.

Chapter 27 The Role of Hospitals in the Provision of Health Care

The various arrangements through which hospital services are provided to the people of Ontario today were described in Chapter 7. In the present chapter we propose to consider some of the important problems which have arisen in connection with the existing system of supplying hospital services to date, and to suggest ways of overcoming these problems in the future. Our discussion here will move from the political and economic issues relating to the supplying of hospital care, through the matter of the hospital's role in medical education, to the problems of internal hospital organization.

Political and Economic Problems of the Hospital System

A large volume of literature on the problems of hospitals has grown up in recent years, much of it concerned with the economic and financial aspects of providing hospital services. The principal points of interest in the "economics" of hospital systems have been the availability of hospital services to the public and the costs of providing these services. Hospital care prepayment plans have proliferated throughout North America since World War II, and it is now common to have a wide range of hospital services available to the general public without the need for direct payment at the time services are rendered. Recently, the large increases in the total bill for such services has become one of the major public issues in the health field. Because governments have become deeply involved in organizing and financing the supply of hospital services to the community, these issues of availability, utilization and cost have become important and often controversial political issues.

Political Issues of Hospital Organization

The principal "political" issue arising from the present pattern of hospital care organization in this province, as elsewhere in Canada, is the issue of local autonomy versus central control. We must recognize that a number of important problems in the organization of our system for providing hospital services spring from this general source.

We saw in Chapter 7 that most of our short-term general hospitals in this province were established by religious, lay or municipal bodies for the purpose of providing hospital services to particular communities. In this way a large measure of "local autonomy" was built into the system from the outset. One advantage of

this approach was that it meant the policies of the local hospital would tend to reflect local needs and preferences. To improve the facilities, to limit them, to extend services, or to withhold them were matters which would be determined in this kind of hospital system by the community's willingness and ability to devote funds to these purposes. The people responsible for making these decisions would be local people known or known of in the community. This feature of the community hospital system remains attractive. Despite the changes in hospitals and in the method of financing hospital care which have occurred in recent decades, the principle of local autonomy for hospitals remains, we are assured, an important element in provincial health policy in Ontario. The Ontario Hospital Services Commission (OHSC) has stated in its brief to this Committee that:

> The policy is that hospitals should be encouraged to continue to develop as community-sponsored and operated institutions with their own hospital boards of trustees having authority to make decisions affecting the hospital.[1]

Yet the system of local, autonomous hospitals, run by their own boards of trustees, also has certain defects. One of these is the variation in the level and quantity of hospital services from one community to another. As long as the extent to which such services were required could be thought of as being properly a matter of "local option", this created no serious problem. But once it came to be believed that the availability of some uniform standard of such services should be a citizen's right, regardless of where he lived in the province or even in the country as a whole, the situation became quite different. The federal Hospital Insurance and Diagnostic Services Act in 1957 brought with it the establishment of hospital prepayment plans and provincial agencies, such as the Ontario Hospital Services Commission, to administer them on a province-wide basis throughout Canada. Consequently provincial governments suddenly became directly or indirectly involved as a "third-party", in the provision of hospital services. The government, or its agency, has accepted the task of paying the patient's hospital bill to the hospital supplying such services.

Although this is called a hospital "insurance" plan, the effect of measures to make its coverage virtually universal and compulsory has given it the appearance of a "tax" supported hospital services system. Whether they are called "premiums" or "taxes", the charges levied on the population for these services have become clearly identified as the responsibility, not of local hospital boards, but of the provincial government. Consequently the government has asserted its right to regulate the quantity and quality of services provided by hospitals in the province.

In this province, the Ontario Hospital Services Commission has, as we noted in Chapter 8, the "power of the purse" over most short-term active treatment hospitals. Specifically, it has the tasks of approving the expansion of hospital facilities, of determining the amounts of grants for hospital maintenance and con-

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[1]Ontario Hospital Services Commission, Brief to the Committee on the Healing Arts, 1968, p. 14.

struction, and of operating the hospital care insurance plan through which these hospitals are paid for virtually all the services they provide. Through these and its other powers the Commission has acquired the capacity to shape the provincial hospital system or to attempt, in its words, "to promote the development throughout Ontario of a balanced and integrated system of hospitals and related health facilities".[2] There is a sense, then, in which the provincial government has become responsible for the supply of hospital services available in the province, even though hospitals themselves remain formally "independent" institutions. Because the great cost of building and equipping hospitals to today's standards is quite beyond the financial resources of private philanthropists and local governments, the building of new hospital facilities depends upon the willingness of the provincial and federal governments to provide capital funds. And because the revenues of hospitals are almost entirely derived from OHSC payments made on behalf of "insured" patients, the current operative budgets of hospitals are, in a similar sense, ultimately determined, at least as a "global total", by these same authorities.

This new situation has created a number of problems, while at the same time it has solved others. Certainly hospitals in Ontario today are more financially secure than ever before. No longer must hospital boards of trustees be chosen primarily for their ability to raise money for capital purposes. No longer must hospitals depend upon tag days and emergency appeals to local businessmen to meet operating costs when patient fees prove inadequate to cover expenses; nor must they rely on the use of voluntary or other inexpensive workers to keep their labour bills low. At the same time, this diminution of the local hospital board's financial problems has also diminished its importance. While it remains responsible for preparing the hospital's budget, that budget must be acceptable to the provincial hospital authority. If the role of the hospital trustee is to reflect local preferences and needs for the quantity and quality of hospital services available in the community, this role is at least constrained by the centralization of effective financial decision-making in the OHSC.

We have not attempted to weigh the merits or otherwise of these changes in the role of the hospital trustee. But it is apparent to us that this role has been altered, and on balance probably weakened, by the events of the 1960's. In addition to the centralization of budgeting decisions at the provincial level, trustee control has been affected by the growing complexity of hospital medicine and the trend towards professional hospital administration. Eroded from above by the OHSC and from below by professional hospital administrators and increasingly sophisticated medical staffs, to say nothing of militant groups of hospital employees, the future of the hospital trustee has become uncertain.[3] Quite apart from the implications of this for the management of hospitals as referred to in Chapter 7, there is also the question of the trustees' future effectiveness as repre-

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[2] *Ibid.*, p. 2.

[3] See, for example, R. A. Hay, "The Trustee-Government Relationship in Hospital Management", *Canadian Hospital*, August 1967, pp. 51-54.

sentatives of the public served by the hospitals. If the trustees of the local hospital in a community are denied, or choose to abdicate, responsibility for imposing the wishes and preferences of their community as to the quality and quantity of hospital services made available in it, we must seek alternative means of providing consumer and public representation in hospital planning and operation. Furthermore, we question whether the individual hospital is the most appropriate planning unit in any event. We have noted in Chapter 24 the announced intention of the provincial government to follow the recommendation of the Ontario Council of Health in establishing a regional system for health services, based on health sciences centres in Southern Ontario and focused at Thunder Bay and Sudbury for northern areas. We have undertaken no study which would allow us to comment authoritatively on the merits of a regional system. Taking the government's decision as a framework, however, we urge that hospital planning take place within this context, in relation, that is, to the broader health objectives of the regions and the province. By incorporating local trustees into a system of regional and ultimately province-wide health planning bodies, the Committee believes that community-level decision-making can find a useful place in a system which also promises the advantages of central planning and control.

Recommendation:

335 That when, as described in Chapter 24, Regional Health Councils are established in Ontario, the coordination of hospital facilities be viewed as part of the larger problem of regional health planning.

We will return to this after considering some of the important economic issues relating to contemporary hospital problems, for it is these which appear to be largely responsible for pushing hospitals into more highly organized systems of central planning and control.

Economic Issues of Hospital Care

The "cost" of hospital services to the community is undoubtedly the principal economic issue relating to the hospital sector of our present health services industry. As both factors determining our total hospital bill — namely, hospital utilization and costs per patient day — continue to increase, the bill is rising from year to year at a rate which has caused widespread alarm. Many of the groups which we have been studying have been blamed for this state of affairs. Physicians, nurses, other hospital employees, boards of trustees, and the architects of the hospital insurance plan, have all at one time or another been implicated in what seems widely to be held as an uncontrolled and excessive rate of increase in our spending on hospital services. Of the two factors affecting this expenditure, cost per patient day appears to occasion greatest concern. Yet the reasons for the rapid increase in our total hospital bill are complex; they are obscured by lack of adequate empirical knowledge, and discussions of them are confused by a number of vexing conceptual difficulties arising from the nature of hospital work itself.

Although the Committee has not undertaken a study of hospital costs as such, concentrating instead on the various occupational groups involved in the healing arts, it is recognized that much of the practice of these groups is intimately connected with hospitals and their operation. Indeed, to the extent that hospitals are becoming more, rather than less, important as centres through which health services are "delivered" to the community, we might expect to find one of the reasons for the rapid growth in the community's total hospital bill in this trend itself. We are confronted here by the possibility that an important change may be taking place in the pattern of health service utilization in the community, a change which may have important effects on the overall organization and practices of many of the groups of health workers with which we have been concerned.

The total hospital bill of the community is determined by the quantity of hospital services provided and the prices paid for these services. The quantity of services provided will increase as the population grows, and also as the population, for whatever reason, comes to require more hospital services per person. The services in question here may not, of course, be homogeneous over time, for important quality changes may occur with the advance of medical technology and standards of patient care. The identification and treatment of such quality changes is one of the vexing conceptual difficulties referred to. Were "units of hospital service" standardized, this difficulty would be eliminated. But at present such a standardization is not available.

The second element in the community's hospital bill is the cost of providing hospital service. This is conventionally measured in terms of the average cost of a day's stay in the hospital. These *per diem* expenses reflect the quality of care and accommodation provided and the costs of the labour and other inputs used to provide patient care and treatment.

We will consider each of these determinants of the hospital bill in turn, looking first at what influences the quantity of hospital services provided and then at what influences the cost of providing this quantity of services.

Utilization of Hospital Services

A simple measure of the amount of hospital care supplied to the community is the number of patient days of care provided per 1,000 of population. The data in Table 27.1 show that the number of days of care provided in public general and allied special hospitals in Ontario has increased greatly in the past decade and a half, rising from 1,418 in 1953 to 1,834 in 1965, declining slightly to 1,824 in 1966. Another measure of utilization, the number of admissions to hospital per thousand population has also increased. As shown in the same table, admissions per 1,000 of population increased from 128.4 in 1953 to 146.8 in 1966. It is notable that over this period there appears to have been no reduction in the length of time patients remain in hospital once they have been admitted. Indeed, the mean length of stay per admission has been increasing.

TABLE 27.1

Admissions and Patient Days, Public General and Allied Special Hospitals in Ontario, 1953-1966

	1,000 pop.	Admissions	Admissions per 1,000 population	Patient days (000's)	Patient days per 1,000 population
1953	4,941	634,273	128.4	7,008	1,418.3
1954	5,115	683,102	133.5	7,490	1,464.3
1955	5,266	711,940	135.2	8,013	1,521.6
1956	5,405	754,861	139.7	8,472	1,567.4
1957	5,636	790,980	140.3	8,883	1,576.1
1958	5,821	815,746	140.1	9,114	1,565.7
1959	5,969	835,608	140.0	9,638	1,614.7
1960	6,111	868,789	142.2	10,224	1,673.0
1961	6,236	897,859	144.0	10,646	1,707.2
1962	6,351	915,184	144.1	11,087	1,745.7
1963	6,481	950,195	146.6	11,596	1,789.2
1964	6,631	982,683	148.2	12,127	1,828.8
1965	6,788	993,997	146.4	12,449	1,834.0
1966	6,961	1,022,071	146.8	12,696	1,823.9

SOURCE: DBS, *Hospital Statistics,* Vol. VI, 1965 and Vol. I, 1966, Queen's Printer, Ottawa.

A good deal of attention has been paid to the possibility of checking the rise in the community's total hospital bill by controlling utilization rates. The implication of this approach seems to be that present utilization trends are not justified, that hospital services are being used unnecessarily. To appraise the validity of this suggestion we must attempt to identify the factors which govern the utilization of hospital services.

At least four specific groups of people are involved in the determination of overall utilization rates. First, there are the suppliers of hospital facilities. We have already identified these as being the "owners" of hospitals, the various religious, lay, and municipal bodies which have established the general active treatment hospitals with which we are mainly concerned here.

The extent of the facilities and services they are able to provide is, as we have also seen, now strongly influenced by the policies of the OHSC, which finances hospitals. Between them, the owners of hospitals and the OHSC decide how many hospital beds will be available. There is reason to believe that this has a more complex bearing upon the hospital utilization than the simple "availability" of beds consideration might at first seem to imply. If these decision-makers provided more than enough hospital accommodation, it might seem that their policies would cease to be the "operating" determinants of overall utilization, giving way to the other factors considered below. But instead, it appears that such a surplus of hospital beds is unattainable, because the very availability of a hospital bed appears to ensure that it will be utilized. There are reasons to believe that this

is a case in which supply creates its own demand. Who, then, is responsible for filling hospital beds as they are created?

Here attention must shift to the physicians. Despite the provisions of our hospital legislation which require that hospitals must accept patients who require such services, it is the patient's physician who has admitting privileges and it is the physician who authorizes admission, determines length of stay, and authorizes discharge. Thus, in a major sense, it is the physicians of the province who control the utilization of hospital services by the population.

The fourth party referred to above, the consumer, remains a relatively passive figure in the process of controlling hospital utilization. Most patients can use hospital services only if the hospital has provided "beds", if the OHSC will pay the hospital's bill for the care and treatment required, and if a physician will "prescribe" such care and treatment.

By removing the immediate financial constraint which could conceivably be used to restrict access to hospital services, prepayment plans may increase utilization in a population. But the medical constraints remain. We must ask, therefore, if there are any reasons to believe that physicians may be inclined to overprescribe hospitalization, thereby causing utilization rates to be "excessive" and making the total hospital bill larger than it otherwise would be.

The physician is, of course, subject to pressures from patients, hospital administrators and even society at large to hospitalize patients instead of dealing with their problems in other ways. We have already noted the change in public attitudes towards hospitals and the rise in expectations concerning their capabilities to cure disease. A public which sees the hospital as the source of the best treatment for what ails them will exert pressure on their physicians to have them so treated. Hospital administrators faced with the alternatives of an empty bed costing many dollars per day, or an occupied one returning full revenues from the Ontario Hospital Services Commission against these costs, may not urge their medical staffs to be as selective in admitting or as prompt to effect discharge as they might be. And a society which provides prepayment for care and treatment of those admitted to hospital for acute ailments but not for care provided in alternative types of institutions should not be surprised if physicians are reluctant to refuse admission, or are slow to grant discharge, to patients who cannot otherwise be provided for. In this connection it is relevant to note that the increase in length of stay per admission alluded to earlier appears to be in some part due to an increase in the number of older patients requiring long-term care being admitted to high-cost short-term active treatment hospitals. As the length of life is increased for more of our population, the need for longer-term care facilities increases and if we are slow to provide such facilities, the utilization of our short-term general hospital will continue to rise simply because they are the available alternative.

The physicians' resistance to these pressures may be weakened by preferences of their own. We have noted the increasing tendency for physicians to use hospital

services as a means of conserving their own time, energies and other resources, and for many physicians to concentrate their activities at the hospital rather than at their private office.

We lack objective means by which to measure these forces making for greater utilization of hospital services, and we have no estimates of the extent to which they account for the rising hospital bill in Ontario. Nevertheless, several measures may be proposed to effect the more efficient utilization of active treatment hospitals. The Miller Commission in the United States recommended the use of incentive measures by health insurance programs, whereby they would reward health care purveyors who affected lower per diem costs through more efficient utilization by, for example, providing bonuses based on a percentage on the difference between the actual costs incurred by these purveyors and the "normal costs" of services.[4] Such suggestions hold considerable promise for Ontario.

In addition, the provincial government should intensify its efforts to provide convalescent and chronic care in institutions designed for such purposes and in the patient's own home. The Committee sees the former as part of a rationalization of hospital facilities on a regional basis, with some existing smaller hospitals possibly being converted to serve such purposes. At present, the establishment of nursing homes for chronic care is being encouraged by the Department of Health, which recently undertook a program of licensing such institutions on an annual basis under the Nursing Homes Act[5] 1966 and the Homes for Special Care Act.[6] The Department does, however, expect to see a trend towards larger and more efficient nursing homes and the closing of smaller units. In 1968, 471 institutions were licensed under the Nursing Homes Act 1966 and 249 under the Homes for Special Care Act (there is some overlap in these figures since some institutions hold dual licences). Together these institutions provided a total of 13,891 beds. Thirty-five nursing homes are covered by OHSC. Another type of relatively low-cost facility which may lessen the inefficient utilization of higher cost active treatment hospitals is the "motel"-type accommodation adjacent to general hospitals; these are becoming popular in some centres in the United States for accommodation of patients during their preparation for diagnostic tests in hospital or during short-term uncomplicated convalescences.

The above facilities present attractive and relatively low-cost alternatives to active treatment hospitals for the provision of important surveys, and should be considered in any program of rationalization of hospital facilities. We would suggest two additional promising approaches. One, expanded domiciliary care programs, is related to our proposals for an expansion of outpatient and home care facilities and payment plans. We also believe that by contributing to the

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[4]*Report of the National Advisory Commission on Health Manpower,* Vol. I, Washington, D.C., 1967, pp. 68-69.

[5]S.O. 1966, c. 99.

[6]S.O. 1963-64, c. 39.

provision of more comprehensive medical care, group practice by physicians may help to reduce the need for hospitalization for certain conditions (see Chapter 29).

Recommendation:

336 That substantial use be made of pilot programs and evidence available from other jurisdictions regarding improved utilization of health facilities. Continuous study of the results of such programs should be undertaken by the appropriate public authorities, including the Department of Health and the Ontario Council of Health and positive steps taken to implement programs based on the findings of these studies.

Per Diem Costs

By far the largest part of the increase in the hospital bill for Ontario in recent years has been attributable not to increased utilization but to increases in the cost of providing a day of hospital care. Between 1965 and 1967, for example, the gross operating costs of public general and allied special "hospitals" in Ontario increased by 35.5 per cent. Less than one-fifth of this increase is estimated to have been the consequence of an increased number of patient days of hospital care being provided. The remaining part of the increase — i.e., more than 80 per cent — was attributable to higher costs of providing a day of care in these institutions.[7]

Breaking down the costs of a day of hospital care, the largest single item is for labour. Hospitals, like other businesses and agencies providing personal services are highly labour-intensive, with over two-thirds (66.9 per cent in 1967) of total operating expenses being in the form of wages and salaries. It is not surprising, then, to find that increases in labour costs have a large effect on the total operating expenses of hospitals. Thus, between 1965 and 1967, about 55 per cent of the increase in hospital operating costs in Ontario was attributable to increases in labour costs. Of this, even when we abstract from the effect of the increased number of patient days of service provided, we find that 13.5 per cent out of the increased labour costs was the result of more paid hours of labour employed and the remaining 41.5 per cent was the result of higher wage and salary rates.

Outlays for non-labour items, such as medical and surgical supplies, drugs, administration, food, laundry, and so on, also increased, making up the remaining 45 per cent of the increase in per diem cost increase. This, too, was the consequence of both increased quantities of these inputs being used and higher prices paid for them per unit.

It is not difficult to explain the increases in hospital costs resulting from rising prices paid per unit for labour and other inputs. It is more difficult to account for the increase in the *quantity* of these inputs required to produce a "day of patient care". The prices paid by hospitals for supplies, food, linen, utilities and

[7]See OHSC, *Annual Reports*, 1965, 1966, 1967.

so on have been rising as a result of general increases in the prices of all goods and services in the economy. As with all these other commodities, there is a complication introduced by changing "quality" in these items. More and more hospital supplies, for example, are being provided with "labour" built into them. Such items as prepackaged surgical supplies and injectables are understandably more expensive than they were in their less convenient and less effective older form. Yet these labour-saving innovations have not resulted in less labour being used in hospitals. As we have seen, labour inputs have also been rising.

Any assessment of these trends is made difficult by the fact that it is impossible to measure the efficiency of hospital operations by relating physical inputs to physical outputs. The product of hospitals is simply not adequately quantifiable in terms of "days of care"; we want to know what kind of care is given and to what effect. Consequently the increasing quantities of labour and other inputs referred to above cannot be taken as evidence of falling productivity in hospital operations. Presumably they reflect an increase in the quality of the care and treatment given in hospitals, but again we have no way of measuring this. We might expect such improvements to show up in a higher level of health in the population as a whole; but, of course, we are unable to separate changes in morbidity and mortality caused by improved hospital services from changes attributable to other health services or just to rising standards of living, including the availability of more food and better housing. Or, we might expect improvements in the quality of hospital work to show up in declining average days of hospital care required per admission, for this would suggest that treatment was effective and that more people were being provided with these services. But, in fact, we have seen that the length of stay is not decreasing, and that in recent years the average length of stay in hospital has actually lengthened. Thus, it appears that changing medical technology may often *increase* rather than decrease, the inputs of labour, equipment and supplies required to provide good hospital care for certain illnesses. Between 1963 and 1966, for example, the number of hospital personnel employed per 100 beds increased from 204 to 220.

We must conclude from this that it is impossible to predict the effect of technological developments upon hospital "productivity" in terms of the measures usually applied in manufacturing and other types of productive activity to which hospital work might be compared. New technology, while increasing the quality of hospital services, may or may not effect reductions in average durations of hospital stay or in the amount of labour required to provide a day of hospital care. The point is that in seeking a high quality of hospital services, we face an important problem of cost. This has a number of important implications for the way we view the problem of controlling the size of the province's total hospital bill.

Hospitals, we have seen, have traditionally relied upon cheap labour. Most hospital employees have been female and females have always been paid less than males, even for equal work, in our society. Those males who were required to work as "orderlies" and maintenance men, were usually unskilled, and were

for this or other reasons unlikely to find attractive alternative employment. Many hospitals run by religious orders had large numbers of "employees" who worked for a spiritual rather than a financial reward. And even lay hospitals could, as charitable, service-oriented institutions, offer rates of pay and working conditions well below those available in industry. Now all this is quite changed. We have seen how the need for more highly qualified and otherwise higher quality workers to staff modern hospitals has forced them to compete in the labour market against other kinds of employers. This, combined with changing attitudes on the part of hospital employees concerning their related positions has forced hospitals to attempt to "close the gap" between their wage and salary schedules, to reduce hours of work, to offer comparable fringe benefits, and to improve working conditions.

Hospital wage rates have increased very rapidly in recent years. The average wage rate in Ontario hospitals rose from $1.66 per hour in 1965 to almost $1.99 per hour in 1967, an increase of 19.4 per cent. Over 60 per cent of the increase in the hospital labour costs referred to earlier between 1965 and 1967 was accounted for by this rise in the aggregate hourly rate of pay. Yet the gap is still far from closed, and many hospital employees continue to work for rates of pay which are low relative to those paid in comparable employments. Further substantial increases in hospital costs must, therefore, be expected to occur for this reason. Not having studied these wage differentials, the Committee has no recommendations to make concerning the seriousness of the existing gap or the rate at which it should be closed. But the Committee notes that there is little reason to expect that major relief from the pressure of rising labour costs can be expected by hospitals in the foreseeable future. As productivity increases in industry, wage rates in industry will continue to rise. Hospitals will be forced to compete with industry for the labour they require by offering competitive rates of pay. If, as we suspect, hospital "productivity" continues to take the form of quality improvements rather than a reduction in inputs per day of hospital care, the per diem costs of hospital operations and the province's total hospital bill must continue to rise — even if there is no further increase in utilization of hospital services.

We believe, however, that this rise in our outlays on hospital care can be restrained without sacrificing the community's interest in improving the quality of hospital medical services. In addition to the measures outlined earlier to control unwarranted utilization of hospital services, the Committee recommends that the following approaches to the problem of controlling per diem costs of hospital services should be explored.

Geographical rationalization of hospital facilities to improve occupancy rates and to eliminate excess bed capacity for particular types of care which now exists in some communities. The Committee notes that the OHSC recognizes that this problem exists and that as a consequence the province had at the end of 1966 a

bed:population ratio of 6.8 beds per 1,000 population, 0.55 more than its planning objective of 6.25.[8]

Recommendation:

337 That the Department of Health promote studies to investigate methods of regional rationalization of the hospital system through careful study of bed needs and the range of services offered. Regional health councils should participate in the planning for this rationalization.

More effective utilization of manpower resources by hospitals. The Committee has made a number of recommendations elsewhere in this report urging that a better matching of skills and job assignments be effected by employers of nurses and other classes of trained personnel. It is evident that this will become increasingly important as hospitals find it necessary to obtain the services of more highly qualified technical and medical personnel in the future. In the cases of radiological and laboratory services there appears to be a particularly promising field for breaking down traditional but non-functional restrictions on the types of workers employed to perform administrative and supervisory as well as routine work in these areas of the hospital.

Recommendation:

338 That hospital planning and rationalization should provide for increased utilization of various types of paramedical personnel. Since a large part of the work of the various types of paramedical specialists discussed in Volume 2 is done in the hospital, their efficient utilization requires a rationalization of many hospital procedures.

Expanding outpatient services. The Committee believes that many types of diagnostic and other procedures for which patients are now hospitalized could be (and in some communities are now being) provided on an outpatient rather than on an inpatient basis. One advantage of this would be to permit more effective utilization of the expensive diagnostic and other technical facilities with which existing hospitals are already equipped.

Further experimentation with "progressive patient care" or other methods of integrating hospital and other types of medical and social services in the community. The concept of progressive patient care was described in Chapter 7, where we saw that one effect of this method of classifying patients according to the nature or stage of their illness would be to minimize the amount of time the patient would have to spend in hospital during the course of his illness. At the same time, the Committee recognizes that such an approach has implications for the organization of the health services delivery system as a whole that some

[8]Active treatment, chronic and convalescent beds included.

authorities on the subject cannot accept. Expanding domiciliary care, for example, would seem to involve the hospital in much more extramural work than is even now the case. If the hospital itself is to be organized into progressive patient care units, entrusting the management of home care to the hospital would seem to be a natural and efficient way of organizing what would then be merely another part of the hospital's function. On the other hand, there are those who doubt the wisdom of expanding the hospital's role in this way. As one Canadian authority has put the opposing view:

> Some people . . . would see the hospital extending itself into the community and taking the responsibility for developing domiciliary care programs, diagnostic and treatment services which could be given within and without the hospital walls.
>
> . . . in theory this is an attractive idea since it would provide for a continuity of care which is highly desirable. In practice, there are many problems to be surmounted and there have been only a few hospitals and hospital administrators who have grappled with the problems and attempted to set up a comprehensive program.[9]

Dr. Roth's principal reservation about this line of development is that "we do not have the organizational and executive competence to deal with the provision of inpatient and domiciliary and outpatient care within one administrative structure."[10] He fears that making the hospital the health centre of the community in this way would yield "nothing but difficulty, an enormous increase in complexity, a breakdown in the provision of services which will be a detriment and a disservice to all". The alternative would be to provide some parallel form of community health institution to organize the provision of these services. One approach to this has already been demonstrated in Toronto in the form of the "Home Care Program of Metropolitan Toronto" established in 1964. It is attempting to integrate various hospital and community home care services, drawing upon hospital insurance and government funds for financial support.

Recommendation:

339 That the government include progressive patient care among the areas of health service to be investigated through the financing of pilot projects, and review of experience elsewhere. Financial support should be extended to experimental programs aimed at developing improved patient care through home care programs, convalescent homes, and nursing homes.

This question of the future role of the hospital in the health services delivery system and of the possible need for the development of new types of institutions

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[9]F. B. Roth, "The Hospital and Health Services in the Future", a paper given at the American College of Hospital Administrators District Assembly, Toronto, December 1, 1967, p. 8, mimeo.

[10]*Ibid.*

and facilities to supplement it is complicated by the fact that the hospital is concerned not only with the provision of patient care, but with the education of physicians and other types of health personnel.

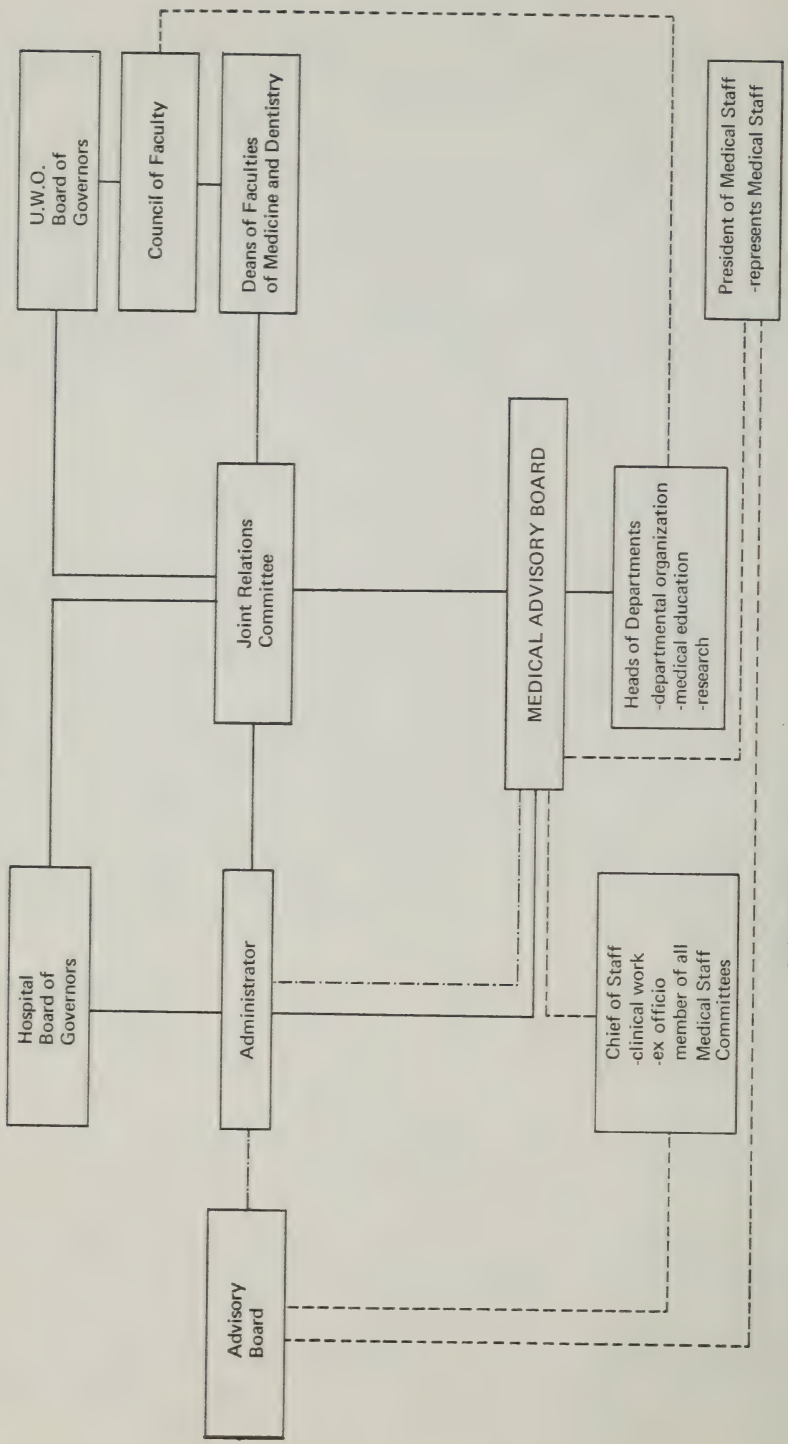
The Teaching Hospital

The increasing importance of the hospital as a locus of the provision of medical education has given rise to some of the most pressing problems facing the health industry today. In addition to the problems of priorities faced by an institution which undertakes both to educate students and to provide care to patients, the provision of education through a complex of hospital facilities which developed in an unplanned and uncoordinated manner is inherently liable to problems of lack of direction and ambiguity of responsibility.

The Affiliation Agreement

Educational activity is most extensive, of course, in the university-affiliated teaching hospitals, in which undergraduate and most postgraduate education is provided. The teaching hospital is defined by the Association of Canadian Medical Colleges as one which includes at least one "clinical teaching unit" — a group of beds under the responsibility of a doctor with a joint appointment to the staff of the hospital and to the faculty of medicine of the university. University teaching hospitals in Ontario have traditionally been semi-autonomous service institutions *affiliated* with the university. The hospital-university relationship is formalized to some extent in an affiliation agreement outlining the terms of the affiliation, including agreement on goals and responsibilities, and provision for joint staff appointments and for Joint Relations Committees composed of representatives from the hospital and the medical school. The complexity of the lines of representation and responsibility between the two institutions and their subdivisions is indicated in Figure 27.1, depicting graphically a fairly typical formal relationship between one university faculty of medicine and one of its teaching hospitals. Even such a complicated formalization greatly oversimplifies the relationship. Much of the "agreement", especially those aspects concerning goals and responsibilities for patient care, instruction and research, is ambiguous, informal, traditional and tenuous. The situation is complicated even further, of course, by the fact that there are several teaching hospitals affiliated with each medical school. The consequence of the above arrangements has been a snarling of the lines of responsibility both for student instruction and for patient care. For example, the head of each department in the medical faculty generally holds an appointment as chief of the corresponding service at one of the teaching hospitals; hence inevitably the chiefs of services in some teaching hospitals are subordinate in their university roles to their counterparts in another hospital. The ambiguity of responsibility is least concerning the direction of the undergraduate educational program; here the responsibility clearly lies with the medical school. In the case of internes and residents, as discussed below, the situation is less clearly defined.

Figure 27.1



SOURCE: Evidence submitted to the Committee on the Healing Arts by St. Joseph's Hospital, London, Ontario, January 1967.

Parochial loyalties and professional ambitions can lead to the rise within the medical faculty of "pressure groups" composed of all or part of the medical staff of particular teaching hospitals who vie with each other over such matters as staff appointments and the provision of clinical and research facilities. The usual ambiguity and informality of the agreement between the hospital and the medical school is often exploited by these groups in achieving their ends. The power of the medical staff groups is greatly enhanced by their ability to ally with one of these institutions in exerting pressure on the other. The astronomically costly duplication and lack of coordination of facilities, of which the Toronto teaching complex provides the prime example, is too often the result of such political activity.

Intraprofessional rivalry is acute not only among members of the medical faculty but between this group and community-based physicians. Here the acrimony arises chiefly over the problem of access to beds. The designation of specific groups of beds as "clinical teaching units" (a hospital may be composed entirely of such units) effectively precludes access to these beds by physicians without a university appointment. Community physicians claim that they lose hospital-based patients to those physicians whose academic appointments give them access to hospital beds.[11] Moreover, some teaching services, having chiefs who are particularly influential in the processes of allocation within the hospital and the university, may be supplied with more beds than they can customarily fill.

Such intrafaculty rivalry over staffing and facilities is only one aspect of the larger conflict between the university and the hospitals and among the hospitals themselves. Resentment on both sides has led hospitals to criticize the insensitivity of the dean's office in the "ivory tower", and the university to object to the perversity of the "prima donna" teaching hospitals. The conflict derives from the different perceptions of the role of the teaching hospital. From the perspective of the hospital itself — the Board of Trustees, the administration and many of its personnel — the prime role is the provision of patient care to meet the medical needs of the community. The medical school and the university, on the other hand, see the hospital primarily as the locus of clinical training. The conflict erupts over such matters as demands on the time of faculty members, internes and residents and the provision of costly facilities.

Salaries for internes and stipends for residents are provided by the hospital, which tends to expect a return in service, a return which many internes and residents consider to be an undue distraction from their training programs. Until recently, faculty members holding joint appointments were paid by the medical

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[11]An important dimension in this "town-gown" rivalry is the conflict between general practitioners and specialists: the majority of community-based physicians who find themselves denied access to the teaching hospitals are general practitioners, and the majority of clinical teachers are specialists. One attempt to mitigate this conflict has been the establishment of Departments of General Practice in teaching hospitals, discussed in Chapter 7 and below pp. 136-137.

school, and donated their time to the care of public patients in the hospital and the running of hospital departments and services in the course of fulfilling their university responsibilities. However, as we have noted, the spread of hospital and medical insurance has meant that more and more of the patients treated by the clinical teacher are productive of income for the physician and revenue for the hospital. In recognition of this fact, the Ontario Hospital Services Commission, the deans of medical schools, and the administrators of teaching hospitals reached an agreement in 1967 whereby a ceiling was to be placed on the total net professional income from hospital and university directed activities of each full-time and major part-time geographic appointee university and hospital staffs.[12] The OHSC agreed to pay 50 per cent of this guaranteed income up to $15,000 (i.e., 50 per cent of a guaranteed income of $30,000), to provide a specified ratio of offices for these appointees, and to pay 50 per cent of the salaries of a specified ratio of secretarial staff. The remainder of the salaries is to be provided by the medical schools from university funds or departmental surplus incomes. Although these arrangements are generally agreed upon as desirable, their implementation at the hospital level is incomplete, and few written contractual arrangements exist as yet. Meanwhile, the incomplete resolution of the problem means that in some cases the medical school may well resent the efforts of the teaching hospital to make its own service requirements rather than the teaching requirements of the medical school the prime determinant of staff appointments. On the other hand, a hospital appointment continues to bring the physician other income in the form of fees from private patients; and the hospital can claim its provision of clinical facilities as a justification for its service demands upon its medical staff.

There have been two types of response to the many problems arising from the teaching-service dilemma. One has been the development of university-owned and operated teaching hospitals, whose staffing and organizational pattern and clinical and research facilities are frankly designed to meet the educational requirements of the medical school and not the needs of the community. Only one such hospital, Sunnybrook in Toronto, is currently in operation in Ontario; McMaster's University Hospital is under construction and scheduled for completion in 1970; and the University of Western Ontario anticipates the construction of a University Hospital by 1972. The educational orientation of these institutions should not be misconstrued as a neglect of community service considerations; indeed, both Sunnybrook and McMaster plan considerable research into and experimentation with community service programs. The point is that these are *model* programs, designed not to meet community needs on a large scale, but to develop techniques for community service and to educate students in their use. The premise upon which the

[12]A "full-time geographic appointee" is one who devotes 100 per cent of his time to university-directed activities. A "major part-time geographic appointee" devotes 50 per cent or more of his time to university-directed activities. The application of the term "geographic" is left to the discretion of the university, and need not mean that the appointee practises in only one hospital. Rather, a geographic appointee may have regional responsibilities involving several hospitals.

university hospitals are based is that arrangements for good teaching are consistent with a high *quality* of patient care if the hospital is freed from the responsibility to provide the *quantity* of service required by the community.

The second type of response to the teaching-service problems has been the launching of a number of studies of the university-teaching hospital relationship in an attempt to replace the present tenuous and confused "agreements" with definitive contracts unambiguously setting out the roles and responsibilities of each institution in relation to patient care, the remuneration of clinical teachers, and the provision of clinical and research facilities.[13] The number of interhospital and university agencies and research projects currently seeking solutions to the problems of coordination is apt testimony to their complexity and urgency.

Accreditation

At present a number of agencies are involved in the accreditation of hospital facilities for purposes of medical education. Teaching hospitals are accredited for undergraduate training by the accreditation committee of the American Association of Medical Colleges as part of the medical school complex. Internship programs in hospital are accredited by the Canadian Medical Association (CMA); furthermore, the College of Physicians and Surgeons of Ontario periodically investigates the CMA-approved internship programs in Ontario. Finally, hospitals are approved for residency training by the Royal College of Physicians and Surgeons. The inconvenience, duplication and waste of valuable time caused under these arrangements could be obviated by the coordination of accreditation procedures as recommended in Chapter 8, Recommendation 11.

The Teaching Patient

One final issue arises in our consideration of the teaching hospital — that of the availability of patients for teaching. As noted above, the spread of hospitalization insurance has meant a progressive decline in the number of "charity" patients — formerly the main source of teaching "material". In making every patient a source of income to his physician, the hospitalization plans may affect the attitudes both of patients and of physicians towards teaching. The patient who is no longer dependent upon the physician's donation of his time for treatment is less likely to submit to the supposed indignity of being "taught upon". The community physician, on the other hand, is less likely to refer a potential source of income to a teaching unit except in rare and/or specialized cases requiring the expertise of the clinical teacher. We have already noted the undesirability of exposing the student solely to such cases. It is essential, therefore, that both physicians and the public recognize a responsibility overriding their private interests. The Hall Commission expressed the view that "It (the training of health

[13]For example, the Association of Canadian Medical Colleges is currently engaged in a study of these issues, and a group under the direction of Dr. L. T. Coggeshall has recently submitted a report to the University of Toronto concerning its teaching hospital complex.

professions) is now a *public* responsibility in the sense that every member of the public must accept the obligation, when hospitalized in teaching hospitals, to serve in the education process".[14] In general we concur with this view, and draw attention again in this context to the need to reduce the "town-gown" rivalry which makes community-based physicians reluctant to refer and hence "lose" their patients to a teaching hospital.

Problems of Internal Organization

Introduction

Our review of hospital services and organization in Chapter 7 led to the inescapable conclusion that the hospital is no longer merely a physical plant housing facilities to be used by others in the provision of health care; it is an organization whose purposes include the provision of medical care and the education of health personnel. Inevitably, in discharging these functions, the hospital becomes involved in the employment and regulation of health personnel, professional and non-professional. It is in this perspective that the hospital must now be viewed and its regulatory processes reconsidered.

If the hospital is conceived as a purposive organization, it stands to reason that its internal organization be informed by and adapted to these purposes. One of these purposes is the provision of clinical care — the Public Hospitals Act of Ontario, in fact, requires all public hospitals (other than those for chronic or convalescent care) to admit any person[15] who is "in need of active treatment".[16] In fact, because his access to the hospital except in emergency situations is mediated through the admitting privileges of a physician, the member of the public does not enjoy this right to active treatment. The internal organization and regulatory processes of the hospital, based on a conception of the hospital as the physician's "workshop", are structured not so much for the benefit of the public and the patient as for the benefit of the medical staff. J. W. Grove has succinctly summarized and criticized the anachronistic theoretical underpinnings of this regulatory structure and process:

> The concept of "the medical staff" in Canadian hospitals is predicated on the right of doctors to organize themselves so as to regularize their dealings with each other, with their patients, with the Board of Trustees who legally govern the hospital, and with the community at large. Indeed, this is not only a right, but a necessity given the peculiarly *voluntaristic* nature of the relation-

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[14] *Report of the Royal Commission on Health Services*, Vol. I, Queen's Printer, Ottawa, 1964, p. 8.

[15] Any person who is not a resident or dependent of a resident of Ontario may be refused admission, except when such a refusal would endanger his life. R.S.O. 1960, c. 322, s. 15.

[16] R.S.O. 1960, c. 322, s. 14 (1).

> ship between the Board of Trustees and the doctors, a relationship that stems from an earlier time when hospitals were generally small and undifferentiated.[17]

To illustrate the underlying rationale of this relationship, Grove quotes the Executive Director of the Canadian Council on Hospital Accreditation:

> The Board of Trustees is legally and morally responsible for the medical care that the patient receives in the hospital. But it does not itself employ the doctors who work in it — with some exceptions (e.g., pathologists, radiologists, and house staff). Moreover, the doctor does not, in most cases, devote his whole time to work in the hospital: he has an outside practice (in the smaller hospital he is quite likely to be a general practitioner), or he teaches in a medical school and does research.
>
> The Board does not appoint a medical staff per se: it appoints doctors who thereby have permission to use hospital facilities . . . . The individual doctors so appointed voluntarily organize themselves as the medical staff of the hospital, and the Board then delegates authority to that medical staff . . . . It does not give authority to doctors, but to the medical staff.[18]

On this view, the hospital is "essentially a place where the individual physician's resources are augmented".[19] The patients he treats in the hospital are his, not the hospital's, patients. In such a situation, the argument goes, the physicians must organize:

> . . . to protect their professional standards by regulating admission to hospital privileges and by scrutinizing the work of their peers; to protect their patients; and perhaps also (though this is less readily admitted) to protect themselves against the possible encroachments of lay control.[20]

Grove's criticism of this rationale is typical of those who doubt its relevance to the reality of the contemporary hospital.

> It may be that this (the arguments quoted) correctly states the formal position as set out in the Ontario Public Hospitals Act and in the important Regulation 523 made under the authority of that Act. There is no doubt that it correctly interprets the policy position of the CCHA, which has done undeniably fine work in regulating and raising the standards of patient care in hospitals across Canada. But it may be doubted whether it reflects the true nature of the modern hospital, except perhaps the small local hospital. A modern hospital of any size is no longer "a place where individual physician's resources are augmented": it is a big organization, and an organization that (whatever the legal situation may be) *employs* doctors as well as a great many other professional and subprofessional people. More-

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[17]J. W. Grove, *Organized Medicine in Ontario,* Committee on the Healing Arts, Queen's Printer, Toronto, 1969, p. 65.

[18]Dr. William Ivison Taylor, "Hospital Medical Staff By-Laws: An Instrument of Self-Government" (sic), *Canadian Medical Association Journal,* 93, 653, September 18, 1965; and J. W. Grove, *op. cit.,* p. 66.

[19]Canadian Council on Hospital Accreditation, Brief to the Ontario Committee on the Healing Arts, quoted in J. W. Grove, *op. cit.,* p. 66.

[20]*Ibid.*

> over, as medicine develops, the doctor becomes less and less the sole, or even the predominating expert in the hospital; he becomes only one of a team of experts and not even "captain of that team", even though the problem may be mainly medical.[21]

The regulatory system based upon the "workshop" theory has the Medical Advisory Committee in effective control of the maintenance of standards of clinical care, even when this care is provided in practice entirely or almost entirely by hospital employees. In daily practice, considerable interprofessional conflict arises from the confusion of lines of authority which may make for a situation in which, for example, a nurse is subject both to the authority of the physician in charge of a particular case, absent but for a few minutes a day, and to the immediate scrutiny and authority of her nursing supervisors.

If indeed those who work within the hospital are members of a team whose purpose is the provision of care to patients, control of the practice of all members of the team by a select group, the medical profession, becomes increasingly indefensible. The foremost practical implication of a change from the concept of the hospital as workshop to the hospital as organization is hence either the representation of other health disciplines on the Medical Advisory Committee, at least for certain of its deliberations, or the creation of a new interdisciplinary advisory board. Either alternative would not only provide a forum for the resolution of interprofessional disputes, but would infuse other than exclusively medical perspectives concerning patient welfare into the process of regulating the provision of care.

We realize that the effect of such a change would be tempered by the traditional attitude of deference to the physician among non-medical personnel. Nonetheless, the provision of a means of reducing the confusion and inequity now apparent in the hospital is essential.

Recommendation:

340 That a greater voice in hospital affairs be given to non-medical hospital personnel, including dentists, nurses, psychologists, physiotherapists, medical social workers, and to internes and residents, and that this voice should be made effective through some appropriate means such as representation of non-medical personnel on an interdisciplinary advisory board in each hospital.

Hospital Privileges

One implication of the above proposal is the limitation of the arbitrary power of the organized medical staff over the granting of hospital privileges to members of the medical and other professions. Consideration of hospital privileges involves us

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[21] *Ibid.*, p. 67.

in an issue of considerable complexity and controversy. We have not undertaken a full-scale study of the problem, and have only limited information concerning quantitative aspects (see below pp. 135-136). We can observe, however, that it does not appear to be a large problem in centres of populations of less than 100,000, but is greater in large urban areas and particularly in teaching hospitals. Our purpose here is to clarify the institutional framework within which the problem has arisen, and to offer some suggestive evidence as to its dimensions.

By-laws of individual hospitals define several classifications of hospital privileges, and the meaning of each designation is not uniform across hospitals. They may, however, be characterized roughly as follows:

1) The *Indoor* Staff consists of those physicians allowed to treat hospital inpatients. It comprises:
   a) The *Active* Staff with full privileges to admit and attend patients within the hospital. Only members of this group may treat indigent or "public" inpatients.
   b) The *Consulting* Staff, members of which may be called in by an attending physician for consultation.
   c) The *Associate* Staff, usually a probationary classification comprising physicians who are awaiting appointment to the Active Staff or whose privileges have been restricted for disciplinary reasons. Members of this group may treat public outpatients and may attend public inpatients under the direction of a member of the Active Staff, and in some cases may attend private patients independently. As the spread of hospital insurance breaks down the distinction between public and private patients, however, the restrictions upon the practice of the Associate Staff member come to apply to all cases, requiring him to treat all patients under the formal supervision of a member of the Active Staff. The extent of actual supervision of Associate by Active Staff members varies among hospitals and indeed among individual members of the staffs.
   d) *Courtesy* Staff, a residual category whose meaning varies widely from an honorary distinction to an expedient in emergency situations. Some hospitals which require specialist qualifications as a condition of Active Staff membership extend Courtesy Staff privileges to general practitioners.

The above classifications have various implications in terms of admitting privileges and participation in medical staff committees. No general rule concerning admitting privileges can be spelled out, except to say that active staff membership implies full admitting privileges. Other categories of indoor staff may or may not possess admitting privileges, and may enjoy differential access to scarce hospital

beds. Hospital admitting staffs, we are told, attempt to be "patient-oriented" rather than "doctor-oriented" in their admission policies and practices. Cases are classified in order of decreasing priority as Emergent (immediate admission is essential to save the patient's life), Urgent (admission is required within twenty-four to forty-eight hours), and Elective (the patient can safely await admission for a longer period — perhaps up to six months). Despite these ostensible policies, however, it is undeniable that there are priorities among physicians as well as among patients in determining access to hospital beds. Many physicians indeed would claim that in the light of the considerable proportion of his time which he donates to fulfilling his hospital responsibilities of public patient care, administration, and instruction, preferential treatment for the active staff physician in the matter of admissions is completely justifiable. The situation is further complicated and the conflict exacerbated in teaching hospitals, where the teaching needs of the hospital enter into the criteria for admission of patients.

The different categories of staff participate to varying extents in medical staff committee work. Again a general rule can be stated only for the active staff, who are required to participate in committee activities as a condition of membership. Members of other categories of indoor staff may, according to local policy and practice, participate formally or informally in committee work and may or may not enjoy voting rights. Courtesy staff is usually excluded from such activity.

2) The *Outdoor* Staff consists of those physicians who may use the hospital facilities, but who do not admit inpatients. This may include both general practitioners and specialists who attend patients in the general medical and specialist clinics of the outpatient department. The Associate Staff usually enjoys privileges in the outpatient department, which may or may not be supplemented by the qualified indoor privileges noted above.

In departmentalized hospitals, a further restriction is placed upon the hospital practice of the indoor, as well as the outdoor staff: the physician or surgeon may practise only within the department to which he has been appointed. Since many departments require specialist qualifications as a condition of membership, such a system can work to the disadvantage of non-certified medical personnel. To counteract this, many hospitals distinguish between "major" and "minor" privileges in a specialty (particularly in surgical specialties) and extend the latter to physicians who are not certified in that specialty. As the Canadian Council on Hospital Accreditation sees it, "minor privileges in any service will allow the medical staff to treat patients when for any cause such treatment does not involve either serious hazard to the life of the patient or danger of disability".[22] The Canadian Council on Hospital Accreditation endorses this type of scheme but, lest it become too restrictive, suggests the granting of "procedural privileges", specifying the particular procedures, more sophisticated than those whose performance "minor privi-

[22]Accreditation guides of the Canadian Council on Hospital Accreditation.

leges" entail, which a physician may perform in a specialty in which he is not certified. Such privileges are granted after a probationary period and on the recommendation of a physician qualified and privileged to perform the relevant procedure. Examples of procedural privileges include such surgical procedures as tonsillectomies and appendectomies, obstetrical procedures as caesarian section, and gynaecological procedures as dilation and curettage.

The implications of the above system of granting hospital privileges cannot be overemphasized. Wherever the range of practice is delimited — whether in confining the physician or surgeon to outdoor practice, to practice only within one department, or, indeed, to practice only of specified procedures, a form of "limited licensure" is in operation. As more and more of the provision of medical care takes place in the hospital, this limited licensure, whether or not recognized by the formal licensing body, the College of Physicians and Surgeons of Ontario, will become increasingly effective.

Much of the acerbity in general practitioner-specialist relations stems from the alleged "exclusion" of the general practitioner from the hospital — the refusal of specialist-dominated medical staffs to extend him privileges, or the restriction of these privileges to 1) outdoor or associate categories which lack admitting privileges and/or require active staff supervision; 2) "courtesy" privileges with lower priority in the order of access to scarce hospital beds.

Despite the many allegations of such exclusion, it has yet to be established clearly on a quantitative basis. The task of doing so is enormously complicated by the existence of various categories of privileges, the variety in their meaning from one set of by-laws to another, and the considerable extent to which physicians may hold multiple appointments (that is, privileges in different hospitals).[23] We can only report here the results of a few preliminary surveys.

A study conducted among its members in 1965 by the Ontario chapter of the College of General Practice of Canada (now the College of Family Physicians) revealed "widespread dissatisfaction with increasing restrictions affecting the G.P. in the hospital".[24] Although this dissatisfaction was slight in smaller hospitals and smaller communities, the study revealed much resentment and frustration on the part of general practitioners in larger urban centres at the "policy of blanket restrictions upon G.P.'s" followed by large departmentalized hospitals, and particularly by teaching hospitals, allegedly "without regard to the competence of the individual doctor".[25]

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[23]The increasing burden of administrative medical staff duties (such as committee meetings) means that it is undesirable for a physician to hold more than one active staff appointment. Some hospitals, indeed, forbid their active staff to hold multiple active staff appointments.

[24]Reported in C. B. Solursh, "Hospital Committee Reports", *College of General Practice Journal*, February 1966.

[25]*Ibid.*

Some quantification of this dissatisfaction is provided by a recent (1967) survey of physicians sponsored by the Canadian Medical Association, part of which was processed by the Research and Planning Branch of the Department of Health. This study also reveals little dissatisfaction in communities of less than 100,000 population. In the central areas of cities of over 100,000, however, 13 per cent of the general practitioners surveyed reported that they were without privileges. Out of this 13 per cent, 3.6 per cent desired privileges in all departments of a hospital, 7.0 per cent in some departments, and 3 per cent were content to have no privileges. In the suburban areas of these centres, 12 per cent were without privileges, and only 2.2 per cent out of this number were content with this state of affairs, the rest desiring some form of hospital privileges.[26]

Dr. Kenneth Clute's 1961 survey of general practitioners in Ontario and Nova Scotia uncovered some dissatisfaction among the physicians concerning their hospital privileges. About 10 per cent of his respondents expressed dissatisfaction; any restrictions experienced by the remainder were felt to be warranted.[27] Teaching hospitals occasioned most of the dissatisfaction, not only concerning their restriction of general practitioners' privileges, but also concerning their supercilious treatment of the general practitioners who referred patients to them.

We have discussed this issue in Chapter 25 and 26 in our general consideration of hospital privileges and of the danger not only to the physician's practice but to his continuing competence posed by exclusion from the hospital context. Here we emphasize the most pressing aspect of this problem — the restriction of the access of the general practitioner to the teaching hospital. Clute feels that this issue:

> . . . is a matter of great complexity and of vital importance to medical education and so to the country as a whole. The whole problem needs, in our view, a thorough re-examination, either by the general practitioners and the specialists working in concert, or, if either group should refuse that, then by an independent commission, probably one having both lay and professional representation.[28]

In Chapter 7 we discussed the establishment of departments of general practice in teaching hospitals, and drew attention to the importance of general practitioners on teaching staffs in recruiting and preparing students for general practice. The benefits of this arrangement both for the individual practitioner and for the educational and research programs of the hospital have been outlined by the College of Family Physicians:

> Participation in the many functions of a Department of General Practice increases the Family Physician's scope and effectiveness in providing total patient care, his major forte. The association with his specialist colleagues, the involvement in training programs for residents, internes and nurses, the

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[26]*Survey of the Medical Profession in Ontario: Tabular Summary,* Research and Planning Branch, Ontario Department of Health, September 1968, Table xix.

[27]K. F. Clute, *The General Practitioner,* University of Toronto Press, Toronto, 1963, p. 131.

[28]*Ibid.,* p. 134.

> proximity of ancillary services, his association with the directors and staffs of these services, and the proximity of scientific and research orientated colleagues, all increase the Family Physician's range of knowledge. Conversely, the Family Physician's wide viewpoints of total patient and family care, give him a unique opportunity to contribute to *clinical teaching* and *research functions* of the hospital complex.
>
> An adequate observation of the natural history of diseases cannot be performed in hospital alone. The department member is in an ideal position to observe a patient both in hospital and at home. The familial incidence of disease, the influence and variability of social and economic factors, the assessment of emotional factors versus organic factors, can all be studied ideally in Family Practice. The opportunity to follow patients in continuity makes provision for the development of programs of observational research which cannot be emulated by any other clinical department.[29]

To realize these benefits, the department of general practice must be more than an administrative fiction — it must possess educational, research and clinical responsibilities.

The implications of the newly established certification in family medicine for this problem are not clear. We have seen that some hospitals require membership in the College of Family Physicians as a condition of appointment to the department of general practice. It may be that certification in family medicine will come to be required of members of departments of general practice, at least in teaching hospitals. While salutary for the educational programs in the hospital, such an arrangement would still effectively bar the possessor of a "four-year M.D." from the teaching hospitals. This may or may not be conscionable; but we agree with Clute that the issue is in urgent need of review.

The problem of hospital privileges, of course, involves health personnel other than the general practitioner, indeed other than the medical profession as a whole. We have noted above the anachronistic theoretical basis of hospital organization which sees the hospital as the physician's workshop. In theory the hospital merely provides the physician with facilities (including ancillary personnel) for the performance of his craft; and its administrative function is confined to the management of these facilities. It is the medical staff which provides medical care in the hospital; hence the management of personnel providing medical care is a function not of the hospital but of its medical staff. Among the practical consequences of this theory is the statutory provision that the determination of the hospital privileges to be granted to personnel involved in the provision of medical care in the hospital be made by the Board of Trustees *on the advice of the Medical Advisory Committee*. In effect, then, members of the medical profession determine the privileges to be granted such health professionals as dentists.

Presently a number of hospitals have dental staffs, but the privileges enjoyed by their members are somewhat more restricted than those of the typical associate

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[29]Manual on Departments of General Practice, *op. cit.*, p. 1.

medical staff member. He may admit patients only with the concurrence of a member of the active medical staff.[30] His attendance of patients is also circumscribed by an ambiguous administrative structure which makes the dental oral surgeon responsible to the chief of surgery as well as to the chief of the dental staff. (The dental staff is usually organized as a separate service.) The details of the hospital privileges granted or refused to health professions other than medicine shall not detain us here. The point, which we reiterate, is that these privileges are determined in practice by members of the profession which dominates the health industry — the medical profession; and that this situation is perpetuated by an outmoded concept of the role of the physician in the hospital as in the complex of health delivery as a whole. We have made recommendations in other chapters concerning the admission of specific groups of health practitioners to hospitals.

Quality Control

The shift in perspective which we propose in this chapter has implications for the method of quality control within the hospital. Medical staff committees perform an invaluable function here, but there is need for a less exclusively medical and a more extensive and integrated approach in keeping with the reality of team practice in the hospital. In Chapter 7 we described the American PAS-MAP programs, and the Hospital Medical Records Institute in Ontario which offers a similar, though as yet less extensive, program, and there recommended the extension of these programs.

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[80]Regulation 523 under The Public Hospitals Act, O. Reg. 102/66, s. 9.

Chapter 28 Patterns of Mental Health Care

"Canada, like most countries of the world, prior to World War II cared for its mentally ill in large mental hospitals, tragically understaffed and operating on a shoe-string budget provided by provincial governments."[1] As the richest of all the provinces, Ontario possesses the greatest investment in such large structures where, until after the war, mental disease was generally isolated. While this approach ensured that the mentally ill were kept out of harm's way, a limited amount was being done to assist in the patients' cure and rehabilitation. As the patient population in mental hospitals continued to increase during the first half of the twentieth century, it became obvious that new methods of treatment and alternative types of facilities were needed to handle psychiatric patients. The past two decades have seen the development of new treatment methods which include group and individual psychotherapy, physical therapies, drug therapies and, more recently, milieu therapy. The contribution of drug therapy especially has made it possible to shift the emphasis from primarily custodial to primarily outpatient and community care, even in the case of the seriously mentally ill. These developments have effected a considerable change in public attitudes and professional working patterns concerning the care of mental patients. The gradual elimination of locked doors within most mental hospitals, aimed at helping patients keep their self-respect and self-confidence, is symbolic of this change.

These trends in better patient care were encouraged by the publication of the Canadian Mental Health Association study "More for the Mind" in 1963. This study concluded that mental illness should be given the same quality of medical care and range of services with which physical illness is provided. It emphasized the importance of decentralizing psychiatric services to hospitals, clinics and local agencies at the community level in order to enable the early diagnosis and treatment of mental illness, the provision of continuing care, and the least dislocation of the patient from his environment. The report published by the Royal Commission on Health Services in 1964 also placed high priority on the mental health needs of the country and made a series of recommendations on how mental health services should be improved. In Ontario, these changing attitudes were reflected in the development of alternative facilities other than the traditional large custodial institutions for the care of the mentally ill. Besides the sixteen public mental

[1]Robert Orville Jones, M.D., F.R.C.P.(C), F.A.C.P., "Future of Mental Health Services in Canada", *Health*, Vol. 35, No. 3, June 1967, p. 14

hospitals and nine training schools for the mentally retarded, Ontario now possesses three smaller regional psychiatric hospitals of 300 beds or less (located at Goderich, Owen Sound and South Porcupine), three community psychiatric hospitals, one public psychiatric hospital (the Clarke Institute of Psychiatry), thirty-nine psychiatric units in general hospitals, and sixty-seven outpatient services sponsored by provincial hospitals and community agencies.

Recent Developments

The expansion of various types of physical facilities was accompanied by changes in other mental health fields. We have already described the development of manpower resources in Chapter 13. Three aspects of developing manpower trends in Ontario merit special encouragement. The first is the increase in the number of practitioners in the senior mental health professions. Because this increase is not expected to catch up with foreseeable demand, we have also stressed the importance of involving the "general physician" in mental health care (see also Chapter 30), the growing emphasis on psychiatry in the undergraduate medical curriculum, and the increasing utilization of less highly trained personnel in the treatment processes. Only with the active involvement of the general or family physician, and the extensive use of nursing personnel, psychiatric social workers, child care workers, and other such auxiliaries can we hope to substantially strengthen our limited mental health manpower resources.

Other developments concern the organizational and legislative changes recently made at the government level. As part of the reorganization of the Ontario Department of Health in 1966, the Mental Health Division was completely restructured. The new Mental Health Division is responsible for all aspects of the provincial mental health program, including standards and patterns of care; the operation of provincial facilities; the approval of programs; the provision of financial assistance to general hospitals and other agencies providing psychiatric services under a local authority; collaboration with other departments and branches of government offering services to the mentally ill and to the retarded; and the coordination of all resources which can be brought to bear on the mental health field. Four branches have been established within the Division: the Professional Services Branch, the Hospital Management Services Branch, the Mental Retardation Services Branch, and the Psychiatric Services Branch. The changes have been made

> . . . with the declared intention of providing the resources that would be necessary within government to guide and direct the further development and expansion of a co-ordinated program of mental health services, with increasing delegation of responsibility and authority at the operating level.[2]

[2]H. W. Henderson, "The Changing Responsibility of Government in the Care and Treatment of the Mentally Ill", a paper prepared for presentation to the Annual Meeting, Canadian Psychiatric Association, mimeo., June 17, 1967, p. 12.

The long-term objective is to make readily available a comprehensive range of services in prevention, diagnosis, treatment or training, and rehabilitation with respect to mental illness and mental retardation in each area of the province, so that continuing care will be available to the patient with the least possible separation from his home and community. One of the major developments instituted by the reorganized Mental Health Division is a program for the treatment and care of children suffering from mental and emotional disorders, an area which hitherto had been badly neglected. This program, outlined in a White Paper tabled in the Legislature by the Minister of Health in January 1967, embraces the two principles of interdepartmental coordination and regionalization of services. We shall return to the subjects of children's services and the planning and administration of the provincial mental health program in later sections of this chapter.

Perhaps the most significant and sweeping of all the recent changes made in the field is the enactment of the Mental Health Act, 1967, an Act which has been termed "a model statute" by the Canadian Mental Health Association and is considered by the Canadian Psychiatric Association[3] to be one of the foremost pieces of mental health legislation in the world. This Act represents a complete revision of the laws pertaining to the care and treatment of those suffering from a mental disorder. The provisions of the Act and the regulations are aimed at removing any stigma attached to mental illness and at providing for the care and treatment of the mentally ill on a basis that is equal to that for physical illness.

> No distinction is made between the psychiatric service in a general hospital and the mental hospital, with respect to the authority, standards, special forms and procedures required. As in other forms of illness, medical judgment is the basis for determining the need for treatment and the manner in which such treatment will be provided. Court procedures have been reduced to a minimum, and the rights and freedom of the individual have been fully protected and safeguarded.[4]

It will be several years before the effects of these forward-looking changes can begin to be realized. In the meantime, services for the mentally ill continue to be inadequate. The facilities which are available in the province at present reflect both the changing approach towards mental illness and the inadequacies which prevent the maximum functioning of progressive programs and an exemplary piece of legislation.

Present Facilities

Inpatient Facilities

In terms of sheer quantity, as revealed in Table 28.1, Ontario is well supplied with beds for the care of the mentally ill. Although estimates of need in this area vary widely, it would appear that by even the most generous estimates the

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[3]*The Medical Post,* February 27, 1968.

[4]Ontario Department of Health, *44th Annual Report,* 1968, p. 74.

TABLE 28.1

Inpatient Facilities in Ontario, 1969

Type of institution	No. of institutions	Bed capacity
Public:		
Ontario hospitals	16	15,517[1]
Community psychiatric hospitals[2]	4	463
Psychiatric units of general hospitals[3]	38	1,218
Facilities for emotionally disturbed children	2	129
Hospitals for the mentally defective	12	6,818
Private:		
Mental and psychiatric hospitals	4	440
Facilities for emotionally disturbed children	3	81
Facilities for retardates	3	283

[1]Includes residential beds.

[2]Includes Clarke Institute of Psychiatry.

[3]As of December 31, 1968, reported in the Ontario Department of Health, *44th Annual Report*, 1968, pp. 75-76. Excludes 206 beds at the Clarke Institute.

SOURCE: DBS, *List of Canadian Hospitals and Related Institutions and Facilities, 1969*, Queen's Printer, Ottawa, Table 1.

25,000 treatment beds in Ontario constitute an adequate, and probably more than adequate, supply. This statement, however, must not be construed to imply an adequacy of mental health care facilities in the province. Two major developments in the field of mental health care have resulted in changes in the organizational requirements for its provision. On the one hand, the range of illness treated has been extended to include minor mental health disorders which may require only short-term or outpatient care. One the other hand, advances in chemotherapy have effected significant reductions in the length of the period of inpatient treatment required for many disorders, while creating a need for follow-up care in the community. The effect of these developments, then, has been to increase the proportion of mental health care which now can best be provided on an outpatient or short-term inpatient basis. Moreover, the therapeutic value of treating the patient as much as possible in the community in which he resides is gaining increasing recognition among mental health professionals. In Ontario, however, the abundance of beds is concentrated in the large, regional mental hospitals under the central control of the Department of Health, rather than in small, local facilities such as community psychiatric hospitals and psychiatric units of general hospitals where much short-term treatment could be more effectively and more flexibly

provided. Such considerations suggest that while Ontario's inpatient facilities may, in aggregate, be more than sufficient, there exists both an imbalance to the detriment of outpatient facilities and a maldistribution of inpatient facilities. The process of rectifying these defects has been made difficult by the existence of the large mental hospitals, which represent an investment in physical plant and strongly entrenched traditions and which have delayed experimentation and innovation. However, as we pointed out earlier and as the following discussion of the main types of inpatient facilities in Ontario will reveal, the 1960's have brought hopeful signs of reform. At both central and local policy-making levels, the major concern is now to develop and coordinate mental health programs within the community.

Ontario Hospitals

The first permanent institution provided by the Province for care of the mentally ill began admitting patients in 1850 at 999 Queen Street in Toronto. In 1968, the sixteenth provincially operated mental hospital was opened in South Porcupine to serve northeastern Ontario. In the intervening years these institutions, along with the nine facilities which were developed to care for the mentally retarded, became "the crucible in which, by blending the elements of clinical study, research, teaching and dedicated service, the evolution of the patterns of care and treatment of the mentally ill and the retarded have been moulded and shaped".[5] However, the ideas of how to treat mental illness have changed, and it was acknowledged that there was still a lot to learn. It became obvious that the provincial structure, with its high degree of centralization and its large, understaffed, and tradition-bound institutions, had failed to keep pace with the development of new patterns of patient care. To remedy this, the Mental Health Division of the Ontario Department of Health has undertaken considerable reform. It has embarked on a program of encouraging the treatment of more types of mental illness through community facilities — private practitioners, clinics and agencies, community psychiatric and general hospitals — thereby reducing the resident populations of its mental hospitals. Moreover, it is seeking to divest these institutions of many of their purely custodial duties through the establishment of special care and rehabilitation homes in the community, a task made possible through the use of drugs. In effect then, the role of the Ontario Hospital is coming to be considered the treatment of the more severe mental disorders requiring generally longer-term and more intensive treatment than that available in the community. And even for many of the more severe disorders, therapeutic methods (such as the use of psychotropic drugs) are effecting significant reductions in the length of stay in hospital.

The operation of these general trends and policies is indicated in the following statistics.[6] Although the average bed capacity of Ontario Hospitals built prior

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[5]H. W. Henderson, *op. cit.*, p. 5.

[6]For a further statistical survey of mental health facilities in Ontario, see Chapter 6.

to 1960 exceeds 1,000,[7] those built in recent years are considerably smaller. The Ontario Hospitals at Goderich and Owen Sound, completed in 1964, have 305 and 300 beds respectively. The most recent, the Northeastern Psychiatric Hospital at Porcupine, was designed with a bed capacity of 300, but within six months the staff of the hospital had determined sixty to be a more appropriate number, removing the rest to unoccupied wards.[8] The annual report of the Department of Health for 1968 reported a significant reduction in the population of its sixteen hospitals for the mentally ill from 12,588 in 1967 to 10,787 in 1968. The decrease has been effected in both active treatment and residential units. Although the absolute number of admissions increased from 1967 to 1968, the rate of increase in discharges was one and one-half times the rate of increase in admissions.

The composition of the population of Ontario Hospitals has also undergone subtle change as the importance of treating milder forms of disorder has been recognized within the mental health community. At the Ontario Hospital at St. Thomas, for example, admissions of psychoneurotics increased from 8 per cent in 1948 to 15 per cent in 1962. Character disorders have increased from 5 per cent to 10 per cent of admissions. Schizophrenic admissions rose markedly between 1948 and 1950, remained at about 29 per cent of admissions until 1954, and between 1958 and 1964 had remained relatively constant at about 25 per cent of admissions.[9] Since the length of stay for psychotic disorders is on the average longer than for minor disorders, these figures do not reflect the actual composition of patient populations. In 1966, psychotics accounted for 46.1 per cent of the population of Ontario Hospitals, psychoneurotics for 2.2 per cent, behaviour and character disorders for 4.2 per cent, mental deficiency for 41.4 per cent, and other disorders for 6.1 per cent.[10] As we shall see, however, facilities other than the regional provincial hospitals have assumed the major burden of treatment of minor disorders.

The reduction of the population of the large Ontario Hospitals must be carried further as more appropriate facilities are developed. Situations such as that which Charles Hanly reported at the Ontario Hospital at Kingston in 1966 can be improved if community rehabilitative and long-term care facilities are available. At that time its population breakdown was approximately as follows: 13 per cent acutely ill but undergoing active treatment, 34 per cent chronically ill, 12 per cent physically ill as well as being mentally ill, 25 per cent domiciliary, 16 per cent welfare patients, who could have been discharged but had nowhere to go.[11]

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[7]D. G. McKerracher, *Trends in Psychiatric Care,* Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, p. 79.

[8]"Without Locked Doors How Can it Be a Mental Hospital", *Globe and Mail,* Toronto, November 7, 1968.

[9]K. M. McGregor, "Trends in Mental Hospitals", *Canadian Psychiatric Association Journal,* Vol. 9, No. 4, July-August 1964, p. 332.

[10]100th Annual Report of the Mental Health Division of the Department of Health, Province of Ontario, 1966, Table 4, p. 53.

[11]C. Hanly, *Mental Health in Ontario,* Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 272.

TABLE 28.2

Population, Admission and Discharges in Sixteen Ontario Hospitals, 1967 and 1968

	1967	1968
Population	12,588	10,787
Active treatment	9,517	8,402
Residential units	3,071	2,385
Admissions	14,836	16,119
Discharges	15,593	17,536

SOURCE: Ontario Department of Health, *44th Annual Report*, 1968, pp. 74-75.

Community Psychiatric Hospitals

The foregoing section, in revealing the deficiences of the Ontario Hospital system, suggests the desirability of small psychiatric hospitals serving the community in which they are located, under the control of autonomous local boards. In the early 1960's, three such institutions commenced operation in Ontario under the Community Psychiatric Hospitals Act, 1960-61. These facilities — the Windsor Community Psychiatric Hospital, the Royal Ottawa Sanatorium, and the Sudbury Algoma Sanatorium — provided a total bed capacity of 229 in 1967.[12] The Clarke Institute of Psychiatry in Toronto, opened in 1966, functions both as a community psychiatric hospital and as a teaching hospital within the University of Toronto complex, with extensive research functions; it is operated under the Public Hospitals Act. Since 1963, the amount of care provided in such institutions has greatly increased, though they remain small. In that year, psychiatric hospitals provided 103 beds and 16,067 days of patient care; in 1967 they provided 435 beds and 99,752 days of patient care.[13]

Psychiatric Units in General Hospitals

The establishment of psychiatric units in general hospitals has been the most widespread response to the need for reform in mental health services. Like the community psychiatric hospitals, these units are designed to serve the communities in which they are located, and being a part of a general hospital are responsible to local boards rather than to the central offices of the Department of Health.

There is, however, a body of opinion adverse to the development of such units. In his supporting study to this report, Charles Hanly also argues against this

[12]Ontario Department of Health, *44th Annual Report*, 1968, p. 75.

[13]*Thirteenth Annual Statistical Report, Psychiatric Units of Public Hospitals and Community Psychiatric Hospitals, 1967*. Research and Planning Branch, Ontario Department of Health, November 1968, Table XXIII.

approach to mental health care.[14] The main objection is that treatment policies in general hospitals are a natural outgrowth of their basic medical purposes. As such, they will remain ill-suited for the care of geriatric patients, the treatment of chronic alcoholics, the most severe psychoses and character and behaviour disorders. They could not achieve the necessary range and flexibility of treatment and care essential to comprehensive community-based mental health hospital services. Because general hospitals are essentially medical institutions, they are quite properly dominated by the medical profession. But mental health hospital resources require essential contributions from the different mental health professions. It is very unlikely that the full and proper utilization of all these resources could be developed within the general hospital environment despite some noteworthy exceptions.

At present, psychiatric units are not intended to replace all other mental health inpatient facilities. Rather, they are used to provide short-term active treatment of less severe disorders, while the Ontario Hospitals continue to serve as regional centres for the treatment primarily of severe and chronic cases. That the development of such a network of facilities could effect substantial reductions in the populations of Ontario Hospitals is apparent when one considers the typical population breakdown cited above. The objection that non-medical mental health personnel in general hospitals may not be well utilized takes cognizance of a difficulty. This will be discussed in a later section in this chapter.

The increase in the past decade in the amount of mental health care provided by psychiatric units has been substantial. In 1958 such units provided 351 beds and 102,475 days of care; in 1967 the corresponding figures were 804 beds and 247,068 days of care. Figures concerning patient days of care offered in 1968 were not available, but we can report an increase in bed capacity to 1,218. In 1967, a total of 5,868 patients were admitted to these units for the first time; 34.4 per cent of those admitted for the first time were suffering from psychosis, 51.5 per cent from psychoneurotic disorders, and the remaining 14.1 per cent from personality and other disorders without psychosis.[15]

Outpatient Facilities

There have been great increases in the amount of mental health care provided through outpatient facilities. These facilities are of three major types: mental health clinics and outpatient departments; private practitioners; and family service agencies.

Mental Health Clinics and Outpatient Departments

Like their counterparts offering other types of health care, hospital mental health clinics and outpatient departments began as clinics for the treatment of indigent patients. These clinics were of necessity confined to the provincially operated

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[14]C. Hanly, *op. cit.*, pp. 262-263, 267-268.

[15]*Thirteenth Annual Statistical Report, op. cit.*, Table X.

mental hospitals, virtually the only sources of psychiatric care. The spread of health insurance and the diffusion of psychiatrists to community hospitals, however, have altered this pattern. Mental health clinics are now operated in the outpatient departments of public general hospitals, where their organization and operation is similar to that of the other medical and surgical clinics, and by private agencies, as well by the provincial government. In keeping with its policy of fostering the development of community-based mental health programs, the Province is encouraging the development of clinics under local auspices, and is reducing its own involvement in this form of service.

Several illustrative statistics suggest the increase in the activity of mental health clinics in the past decade and the changes in their patterns of organization. In 1957, 11,547 patients were treated at mental health clinics; in 1961 the patient load approximated 27,000, and by 1967 it had reached 31,019. In 1961, a total of thirty-four clinics were in operation in Ontario. Twenty-five were administered by the provincial government, including twelve in Ontario Hospitals and three in general hospitals. Travelling teams attached to seven of these clinics provided consultant services to a total of nineteen centres.[16] In addition, nine clinics were operated by municipalities, general hospitals, or private agencies. By 1967, the total number of clinics had increased to fifty-five, only seventeen of which were provincially administered. As more community-based facilities became available, the need for the travelling clinics declined; in 1967 only three were in operation, two under government and one under local auspices.[17]

Methods of treatment at these clinics and outpatient departments are primarily individual and group psychotherapy, psychological testing, and counselling, although speech therapy and electroconvulsive therapy also are available in a few such facilities.[18] Character and behaviour disorders, including alcoholism, account for slightly more than half of the disorders treated, psychoneuroses for approximately one-fifth, and psychoses less than one-tenth.[19]

Private Practitioners: Physicians, Psychologists and Psychoanalysts

For many patients, the initial contact with the system of mental health services is made through the office of a physician in private practice, who diagnoses the disorder and then either treats it or refers the patient. One of the most significant effects of advances in chemotherapy has been to involve the private physician increasingly in preventive care and therapeutic treatment, as well as first-line diagnostic care. Medical practitioners are virtually the only health professionals engaged in rendering mental health services on a private basis. In Ontario, few

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[16]D. G. McKerracher, *op. cit.*, p. 80.

[17]*Twelfth Annual Statistical Summary, Community Mental Health Services in Ontario, 1967*, Research and Planning Branch, Ontario Department of Health, September 1968, Table I.

[18]*Ibid.*, Table V.

[19]*Ibid.*, Table XI.

psychologists or psychoanalysts function outside institutional settings; social workers are exclusively confined to such milieu. These practice patterns are determined more by financial exigencies than by occupational preference, since only physicians are eligible for reimbursement for mental health services under health insurance plans. We shall return to this point in later discussion. Hanly makes the estimate, based on a study of OMSIP claims filed by physicians, that 12 per cent of the mental health care rendered by physicians is provided by psychiatrists, 78 per cent by general practitioners, and 10 per cent by other medical specialists.[20]

We have noted in Chapter 13 an accelerating trend to private practice among psychiatrists. The excessive administrative burdens which have in the past been imposed upon psychiatrists employed by the large provincial mental institutions and the undeniably depressing atmosphere in those hospitals, made evident to the aspiring psychiatrist during his residency, have made private practice a much more attractive alternative for many. As we have seen, however, few psychiatrists now engage exclusively in either institutional or private practice, preferring to carry on private practices as well as part-time appointments to provincial hospitals or other institutions. Psychiatric units in general hospitals provide excellent opportunities for combining the two forms of practice and allow psychiatric practice to assume a form similar to that in other branches of medicine. Such units offer even their full-time appointees freedom from the centralized structure of the provincial institutions, and may allow them to operate a hospital-based practice, while part-time appointees are afforded the privileges of admitting and treating patients seen initially in private practice.

Given that private practice by psychiatrists is increasingly common and popular with practitioners, the question arises as to whether it may cause some waste of specialist skills which might be better utilized on a consultant basis by the general practitioners who are now bearing much of the burden of outpatient mental health care.

We have noted Hanly's report that 78 per cent of the mental health care services provided under OMSIP coverage in 1967 were rendered by general practitioners. From another perspective, it has been estimated that definite psychiatric disorders account for 10 per cent of the practice of a general practitioner, with an additional 40 per cent involving emotional disturbances of varying intensity.[21] Hanly's sample of general practitioners reported that they treat 88.1 per cent of the psychiatric problems which they diagnose, a higher percentage than do any of the other medical specialties surveyed — with the exception, of course, of psychiatry.[22]

Non-psychiatric private medical practitioners may also be engaged in the provision of mental health care on an inpatient basis. If he is fortunate enough to have

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[20]C. Hanly, *op. cit.*, p. 30.

[21]D. G. McKerracher, *op. cit.*, p. 245.

[22]C. Hanly, *op. cit.*, p. 111.

TABLE 28.3

Numbers and Percentages of Patients and Services by Diagnosis and Type of Physician, May-October 1967[1]

Type of physician	Number of patients and services (in thousands)		Diagnosis (percentage of patients and services in each category)							
			Psychosis		Psychoneurosis		Character and behaviour disorders		Other	
	Patients	Services	Patients	Services	Patients	Services	Patients	Services	Patients	Services
General practitioners	38.9	91.2	6.2	6.4	86.4	87.0	4.1	4.1	3.3	2.5
Non-psychiatric specialists[2]	4.1	7.2	16.3	16.7	75.6	80.5	1.7	1.8	6.4	1.0
Psychiatrists	5.5	31.6	12.7	10.4	78.2	84.8	7.3	3.8	1.8	1.0

[1]Data exclude patients treated by physicians on an intensive basis.

[2]General Surgeons, internists, neurologists, obstetricians and gynaecologists.

SOURCE: Charles Hanly, *Mental Health in Ontario,* Committee on the Healing Arts, Queen's Printer, Toronto, 1970, Table 5.4, p. 108.

admitting privileges to a psychiatric unit in a general hospital, the non-psychiatric physician may admit and treat his patients there, availing himself of the specialized skills of psychiatrists on its staff on a consultant basis. Although this pattern is still limited in Ontario, it has been followed with considerable success in Saskatchewan experiments. Failing such an opportunity the physician may admit and treat psychiatric disorders, especially if the illness is accompanied by a physical symptom, in the general wards of a general hospital.

The distribution of the types of illnesses treated by physicians in private practice differs considerably from that treated in mental institutions. No data exist concerning exclusively the services rendered through the offices of private practitioners, but Hanly has analyzed OMSIP claim card data to characterize mental health services provided by physicians in private practice to non-hospitalized persons (see Table 28.3). As might be expected, the proportion of neurotic disorders in the patient loads of private practitioners is much higher than that in the populations of mental hospitals, and is highest in the patient loads of general practitioners. The types of services provided by private practitioners outside the hospital are confined almost entirely to drug therapy and psychotherapy or counselling although the combinations in which these methods of treatment are used vary widely among specialties and individual physicians.[23] The increased use of drugs in the treatment of psychotic illnesses which has resulted in a substantial decrease in the length of stay in hospital for treatable cases involves intensive follow-up care and post-hospital therapeutic management, much of which will be provided by general physicians.

Hanly reports that during the period of his study the number of patients treated privately by general practitioners on a long-term intensive basis was more than three times the number receiving such treatment from psychiatrists, and approximately ten times the number so treated by other medical specialists.[24]

Although very few clinical psychologists in Ontario engage exclusively in private practice, many combine institutional appointments with part-time private practices. Through their private offices, these psychologists provide aptitude and intelligence testing, vocational counselling, and counselling towards the solution of relationship and social problems to a clientele ranging in size from fifteen to over fifty per week.[25] Only the milder mental disorders are treated by private psychologists; psychotics and other severe disturbances are referred elsewhere for treatment.

Most clinical activity by psychoanalysts is carried out in private practice and is devoted primarily to treatment of severely disturbed neurotic patients on an intensive, long-term basis. Psychoanalysts provide only a very small fraction of the mental health services in Ontario, however. In 1967, there were only nineteen

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[23] *Ibid.*, pp. 109-112.
[24] *Ibid.*, Table 5.5, p. 110.
[25] *Ibid.*, pp. 223-224.

psychoanalysts in the province, and only thirteen or fourteen of these were full-time or nearly full-time therapists in private practice.[26]

Group Practice

Group practices of clinical psychologists and psychiatrists, often including psychiatric social workers, are much more extensively developed in the United States than in Canada.[27] In Ontario two private group practices of psychiatrists and psychologists have been established, one in Toronto and one in Hamilton. Although problems of professional cooperation have reportedly been minimal, the fact that insurance schemes such as OMSIP and PSI do not cover mental health services provided by psychologists has presented grave financial difficulties for the groups. We have recommended in Chapter 13 that mental health services provided by clinical psychologists be covered by health insurance plans, provided that appropriate safeguards obtain; we urge such a change in policy again in this context. Group practice schemes afford an excellent means of utilizing the valuable skills of clinical psychologists, while providing that physicians will be involved in the medical aspects of treatment; hence these schemes deserve encouragement.

Family Service Agencies

In 1967 there were twenty private voluntary agencies in Ontario offering professional counselling to families and individuals.[28] Their revenue derives primarily from United Appeal funds; fees, if charged at all, account for only a small fraction of their income and are graduated according to the client's ability to pay. Their staff, consisting of professional social workers with or without the aid of other personnel, such as home economists and child care workers, provide family centred counselling and casework service to clients whose problems are not severe enough to warrant hospital care but who nonetheless can benefit from professional treatment. In doing so, they perform a valuable function in filling the service hiatus between public welfare and the hospitals, in providing service to those who cannot afford private professional counselling but who nonetheless find either that they are not eligible for welfare or that their mental health needs are not met by welfare programs.[29]

Special Areas

In addition to the above facilities there have evolved in Ontario separate facilities for the diagnosis, treatment and rehabilitation of emotionally disturbed children and adolescents, alcoholics and offenders in reform institutions.

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[26]*Ibid.*, p. 123.

[27]See the discussion of such groups in *ibid.*, pp. 224-225.

[28]*Ibid.*, p. 350.

[29]*Ibid.*, p. 351.

Emotionally Disturbed Children and Adolescents

The inpatient and outpatient facilities discussed above include facilities for children. But the inclusion of some child care facilities in our general discussion of institutional facilities masks the fact that the former are usually organized in the form of separate institutions and clinics. Two regional institutions offering both inpatient and outpatient services exclusively for children — the Children's Psychiatric Research Institute in London and the Thistletown Hospital, Rexdale — are operated by the Department of Health. The Children's Psychiatric Research Institute has a bed capacity of 110 for children under twelve and a recent addition of ten beds for boys between the ages of twelve and sixteen. Thistletown has sixty-four beds for children aged six to twelve. Most of the other residential treatment centres do not have facilities or programs to meet the special therapeutic and educational needs of younger and adolescent patients.

Limited services for children are also operated under community auspices. Psychiatric units of general hospitals tend not to admit children; however, separate outpatient clinics for children are operated by eight general hospitals and community agencies in the province.[30]

Mental health services for children are also available in a number of private residential centres under the jurisdiction of the Department of Social and Family Services. These include institutions under the Children's Institutions Act, the Children's Boarding Homes Act and the Charitable Institutions Act. Some of these centres operate group homes, outpatient clinics, day camps and day schools, as well as residential treatment services. Some provide standard child care accommodation only and are not designed to care for the disturbed. Others provide a range of professional services and are designed to accommodate children with varying degrees of disturbance.[31] As yet, most of these facilities are subject to minimal government control. Those operating under the Children's Boarding Homes Act, in particular, are required only to keep a register of children under their care and to maintain certain sanitation and fire protection installations. It is therefore possible that some boarding homes may have emotionally disturbed children under their care who are without benefit of necessary professional services.

The White Paper on Services for Children with Mental and Emotional Disorders released by the Ontario Minister of Health in January 1967 is an attempt to deal with the major problem of shortage of these facilities and the related issues of legislation and accrediting procedures for the maintenance of standards, professional services, staff requirements and research. The White Paper outlined a program for reorganized and expanded services based on regional diagnostic, assessment and treatment centres located throughout the province. This program calls for the collaboration of the Departments of Social and Family Services,

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[30] *Twelfth Annual Statistical Summary, op. cit.*, Table I.

[31] *Report on Residential Services for Adolescents,* prepared by the Section on Child Psychiatry, Ontario Psychiatric Association.

Education, Correctional Services, and the Attorney General's Department, with the Department of Health acting as the coordinating department. The White Paper also resulted in the establishment of an Accreditation Board, as well as standards and procedures for the inspection and certification of children's facilities which seek financial aid from the provincial government. The Accreditation Board is an independent body made up of seven members who belong to various disciplines in the mental health field. Fourteen institutions had applied for accreditation as of September 1969; of these, six had been fully accredited. The introduction of financial aid as an incentive for treatment facilities to improve their standards has met with considerable success. Since application for accreditation is entirely voluntary, however, this measure in no way guarantees a high standard of treatment and care for emotionally disturbed children in all facilities.

To meet the need for more stringent controls, a Bill which provides for the licensing of facilities for emotionally disturbed children was given its third reading in the Ontario Legislature on December 17, 1969. The Bill authorizes the establishment by the Minister of Health of facilities for children suffering from mental or emotional disorders, and provides for the licensing, regulation and control of other such facilities. Provision is also made for provincial grants to children's mental health centres. When this legislation (which will be known as the Children's Mental Health Centres Act, 1968-69) comes into effect, no person shall be allowed to operate facilities or services for emotionally disturbed children without a licence from the Director of the Children's Services Branch, Mental Health Division, of the Ontario Department of Health.

Alcoholism

In 1966, the total number of alcoholics in Ontario was estimated at 112,495.[32] Some alcoholics are treated through the facilities discussed above. However, the leading role in dealing with this problem is performed by the Alcoholism and Drug Addiction Research Foundation. The Foundation has a program of prevention and control, education and information, early detection, treatment and rehabilitation, and continuing research in cooperation with other government and private organizations and agencies of Ontario. Direct services are provided through its regional clinics and specialized treatment centres, both in densely populated areas and the remoter regions of the province. The work of the Foundation is limited by three obstacles: 1) a shortage of physicians, social workers and psychologists; 2) lack of concrete knowledge about the nature of alcoholism and addiction and of recognized effective treatment methods; and 3) difficulty in identifying cases and sending them to treatment because of the basic unwillingness of many alcoholics to recognize themselves as such. The Foundation gave treatment to 4,710 persons in 1966. This total amounts to only slightly more than 4 per cent of the estimated number of alcoholics and drug addicts in the province for the same year.

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[32]C. Hanly, *op. cit.*, p. 342.

Forensic Psychiatry

The forensic service of the Clarke Institute of Psychiatry provides diagnostic and treatment services for the courts of Ontario, for the provincial probation service, and for other persons with problems in delinquent behaviour and forensic psychiatry. The Institute was established under the Ontario Mental Health Foundation Act, 1964 and took over the functions of statutory referrals for pre-sentence psychiatric evaluation from the Forensic Clinic of the Toronto Psychiatric Hospital. Both inpatient and outpatient services are available for the examination and/or treatment of persons on the order of a judge or magistrate.[33]

Clinical facilities for the Juvenile and Family Courts are almost negligible in Ontario and judges experience great difficulty in securing psychiatric assessments for juvenile offenders.[34] There appears to be an urgent need for the establishment of some form of special psychological and psychiatric facilities to service these courts.

The Department of Correctional Services operates eleven reformatories, industrial farms and training centres for male adult offenders, two reformatories for female adult offenders, and ten training schools for boys and girls in the province. Although the Department emphasizes the need to modify the behaviour patterns of those under its care and makes every effort to provide treatment services, it does not have adequate professional staff to deal with the mental health problems of the inmates. The adult reform institutions had custody of 14,009 inmates in 1965-1966, but the Department had only four psychiatrists, eleven psychologists and seven social workers on its staff.[35] Most of these practitioners were located in the Guelph Reception Centre, the Guelph Neuropsychiatric Clinic and the Alex G. Brown Memorial Clinics for addicts and sex deviates at Mimico. Other institutions are less fortunately endowed with professional staff, and depend on their correctional staff for the development of treatment programs and therapeutic communities.

The new Mental Health Act, 1967 aims at easing the limited availability of mental health services to persons charged with or convicted of criminal offences, by providing for a greater accessibility for such persons to psychiatric facilities outside the Department of Correctional Services, and by making their eligibility for admission no different from that enjoyed by citizens in the community.[36] The implementation of these provisions, however, depends on the availability of treatment facilities and qualified professional staff.

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[33]R. E. Turner, "Forensic Psychiatry and Criminology in Canada", paper presented at the 4th International Congress of Psychiatry, Madrid, September 1966.

[34]*Recommendations Regarding Psychiatric Services to the Juvenile and Family Courts,* prepared by the Ontario Psychiatric Association, December 1966.

[35]Department of Reform Institutions, *Annual Report,* March 1966.

[36]S.O. 1967, c. 51, ss. 14-18.

Research

Mental health research, which is generally described as meagre in Canada, is comparatively better developed in Ontario than in other provinces. The Ontario Department of Health employs the principle that all mental health research of high quality should be supported, with the sole reservation that the amounts allocated would be dependent on the resources of the province.

Research activities in the mental health field are coordinated by the Ontario Mental Health Foundation, an independent body established by a special act of the Legislature in 1961, with broad terms of reference relating to the fields of research and education. Its membership is non-professional, but it is advised by an advisory medical board which, together with its subcommittees, includes representatives of both the behavioural and the biological health sciences. The main sources of research funds come from grants made by the provincial and federal governments. For the fiscal year of 1968-1969, the Ontario Mental Health Foundation spent $932,261 in support of research projects, research scholarships, associateships and fellowships. Of this total, $195,958 came from the federal government under the National Health Grants program, while provincial funds accounted for the remaining $736,303.[37] This represents the major portion of all monies spent by Ontario on mental health research but does not include 1) research projects conducted in the public psychiatric hospitals and hospital schools which are funded by appropriations from the hospital budgets; and 2) research projects which are conducted or sponsored by the Research and Planning Branch of the Ontario Department of Health, and by the Medical Research Council of Canada.

The paucity of medical research in Canada has often been a subject of concern in the health field. The Ontario Psychiatric Association, in its study of various areas of mental health care, has repeatedly urged increased government provision for psychiatric research facilities, funds and personnel.

Recommendation:

341 That the Government of Ontario should place a high priority on research in the mental health field when planning for the allocation of health funds, not only that more effective methods of treatment may be developed, but that potential mental health professionals may be attracted to enter and stay in the field.

Conclusion*

The above survey of government and private facilities reflects a thrust towards reform in the mental health field, but much remains to be done. The movement of

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[37]Ontario Mental Health Foundation, letter to the Committee on the Healing Arts, December 10, 1969.

*See minority opinion, pp. 226-227.

psychiatry into the community by the building of small community psychiatric hospitals, the establishment of psychiatric units in general hospitals, and the increased availability of ambulatory services has made mental health care more easily available and attractive to those who need it. At present, Ontario is relatively well provided with facilities for the identification of problems and the treatment of acute disorders. Other aspects of mental health care — prevention, treatment for those suffering from psychoneurotic disorders, and the rehabilitation of all mental health patients — need substantial further development.

In order to strengthen the preventive program, means will have to be found to enable mental health professionals to spend more time in providing psychiatric aid to schools, courts, welfare agencies, and so on, rather than only providing direct patient services. In this connection, public education programs also are important. Much of the work in this area is being done by the Ontario branch of the Canadian Mental Health Association, a voluntary association founded in 1919 by Dr. C. M. Hincks. The primary purpose of the Association is to promote the coordination of existing mental health facilities to improve the quality and availability of mental health services, with a strong emphasis upon public education concerning their utilization and support. Towards this end, it sponsors workshops and planning groups at both the community and the national levels. Its community work involves school nurses, industrial physicians, social welfare agencies, family physicians, hospitals and churches, and other persons who possess the training and the opportunity to detect nascent and existing mental and emotional disorders.

Facilities for the rehabilitation and continuing care of patients provide an alternative to inpatient care and prevent unnecessary long-term hospitalization. We have already pointed out that Ontario has an adequate supply of hospital beds for mentally ill patients if such beds are properly utilized. Unfortunately, as the composition of the patient population at the Ontario Hospital at Kingston shows,[38] a high percentage of the beds are being occupied by persons who should not be there but who are not discharged because they have nowhere else to go. In this connection Hanly has proposed a rehabilitation program for those patients who will not benefit from further active hospital treatment but who are capable of living and being gainfully employed outside the hospital. Stated briefly, this project calls for:

1) Adequate diagnostic procedures to select such patients.
2) Well-designed industrial rehabilitation programs with carefully selected jobs for some patients and special closed workshops for others.
3) More adoptive and/or special homes in the community.
4) Adequate staff to run these programs at supervisory and subprofessional levels.
5) Increased government aid to adoptive and special homes to encourage more families to provide such facilities in the community.[39]

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[38]See p. 144.

[39]C. Hanly, *op. cit.*, pp. 286-287.

In order to increase the efficiency and therapeutical effectiveness of inpatient treatment given in the provincial psychiatric hospitals, the Committee feels that the establishment of such rehabilitation services is urgently needed.

Recommendation:

342 That a study be undertaken by the Province of Ontario to examine the possibility of the immediate development of appropriate facilities for the retraining, after care and rehabilitation of patients discharged from psychiatric hospitals.

As the development of preventive and rehabilitative programs as well as treatment programs for those suffering from milder forms of mental illness are dependent upon an adequate supply of mental health manpower resources, the most crucial problem facing Ontario is an acute manpower shortage. Ontario, like the rest of Canada, has relied heavily on medical authority in the care of the mentally ill. Psychiatric services have begun and come to be identified as a specialty branch of medicine. This has meant that most mental health services must be provided by, or at least given under the supervision of, a member of the medical profession. Since medical manpower is in short supply and can be produced only by a lengthy and expensive educational process, the effect of heavy reliance on medical responsibility has been to intensify the shortage of skilled personnel available for the provision of mental health care. Psychiatrists in Ontario have been occupied mainly with the treatment of the more acute forms of illness, while the majority of disturbed patients — those suffering from psychoneuroses — have been neglected. The Committee believes that a strong complement of psychologists, social workers, child care workers, occupational therapists and other such sub-professional workers is urgently needed, especially for the provision of preventive and rehabilitative services. An obstacle to the development of non-medical manpower resources is the failure of some medical insurance plans to cover mental health services when such services are provided by non-medical professions.

Recommendation:

343 That in the field of mental health therapeutic services be insured by publicly financed health insurance plans whether provided by a physician or by non-medical personnel recognized as being qualified to provide the services.

While the recommendations we have put forward here have been aimed at the solution of immediate problems, we do not feel that the overall issue of mental health care can be taken care of by these piecemeal measures alone. We have discussed very briefly at the beginning of this chapter the way in which the pattern of mental health care has evolved in Ontario. This is not an area in which it can be expected that studies will produce definitive answers on which compre-

hensive long-term plans can be based; but the need for integrated planning is apparent, and every endeavour should be made to determine the extent of the problems caused by mental illness, the nature and quantity of the human and non-human resources the province possesses or is able to produce, the way in which these resources should be allocated and utilized to produce the most economically efficient and therapeutically effective mental health services within the present state of knowledge, and the appropriate organizational machinery which should be set up to assess and review these decisional processes on a continuing basis. In addition to what is being done in Ontario, there is substantial experimentation with different patterns of care in other jurisdictions, and it will be possible to learn much from their experience. The United States, for example, has recently embarked on a vast community mental health centre development under the provisions of the National Community Mental Health and Mental Retardation Act (Public Law 88-64) passed in 1966. The Government of Alberta sponsored a study on mental health in Alberta in 1968, and this study has recommended a new mental health organization and administrative structure whereby mental and physical health services would be integrated at all stages of the delivery process.[40] Saskatchewan has developed a different mental health care system over the past ten years. In 1957, the Psychiatric Services Branch of the Saskatchewan Department of Public Health formulated a master plan for providing comprehensive mental health services to the province. The "Saskatchewan Plan", as it has since been known, is based on the principle of providing comprehensive and total care based in a small mental hospital servicing a circumscribed area of the province and ensuring continuity of care in and outside hospital by making the services easily accessible to the community. Although the plan has been modified considerably since its inception, the guiding principle has remained unchanged. The plan has been so successful in reducing the needs for lengthy psychiatric hospitalization that the estimated psychiatric bed requirement was dropped from four per thousand poulation in 1957 to 1.8 per thousand in 1962. Further development of the plan between 1963 and 1966, which concentrated on the operation of a psychiatric centre to serve the Yorkton area, again changed the earlier estimates. On the basis of the Yorkton experience, it appeared likely that the ratio of psychiatric beds could be dropped to 0.5 to 0.7 per thousand population.[41] The inpatient population in the two provincial mental hospitals was reduced from 3,600 to 1,533 between 1957 and 1966 and is expected to drop further to 800 or less by 1970-1971. The province is now considering abandoning the two mental hospitals altogether. In 1966, Saskatchewan cared for 50 per cent of its psychiatric

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[40]W. R. N. Blair, Ph.D., *Mental Health in Alberta,* A Report on the Alberta Mental Health Study, 1968, Human Resources Research and Development Executive Council, Government of Alberta, Edmonton, Alberta, April 1969, p. 37.

[41]Saskatchewan Department of Health, "The Treatment of the Mentally Ill in Saskatchewan", 1966 (unpublished).

inpatients in psychiatric wards of general hospitals, the rest being cared for in the two mental hospitals and in the Psychiatric Centre in Yorkton. Community facilities were provided through six full-time and twenty-two part-time mental health clinics.[42]

Because of the rather limited knowledge about mental health and mental illness and consequent disagreements among experts of the best modes of treatment, and because of the lack of mental health studies in Ontario of the type we referred to earlier, the Committee does not wish to recommend at this stage any single method by which mental health problems should be dealt with. We feel that the approach which holds the greatest promise is one of experimentation and innovation. The reorganization of the central administration of the mental health program undertaken by the Ontario Department of Health in 1966 has been a step in the right direction. We hope that the new administrative structure can provide the pattern of care and the flexibility it needs to further the development of improved modes of providing health care, including the development of community services, the increased involvement of local agencies, and the reduction of the population in provincial mental hospitals. We have already recommended in Chapter 24 that the operation and administration of the Ontario Hospitals should be transferred from the Department of Health to a separate board, with the Department of Health retaining the prime responsibility for establishment of policies regarding mental health care.

[42]Department of Public Health, *Annual Report,* 1965-66, Province of Saskatchewan.

Chapter 29 Some Patterns of Medical Practice: Group Practice and Health Centres

This chapter deals with group practice, which we shall define in a broad sense, and, incidental to it, increased use of paramedical personnel — two developments in the provision of ambulatory health care services which appear to hold considerable promise for the future. The Committee's interest in group practice is related to the possibilities of such practice promoting developments in health care which we regard as important. In this chapter, then, we are selective in the aspects of group practice with which we deal, and dwell largely on those features of it which are related to the matters in the health care system which we have considered in the rest of this Report.

The Committee is interested in the different forms of practice used in providing health care because the organization of practice does affect the quality of health care and because it may be either more or less efficient in terms of economizing scarce manpower. As the report of the Canadian Medical Association, *Group Practice in Canada,* puts it, "Medicine is fast becoming too important a facet of our highly organized society to be considered solely in the light of the preferences of the individual doctor with respect to the degree of organization which he may or may not bring into the practice of his profession."[1]

The considerations affecting "ideal" forms of practice are numerous. They must include the suitability of forms and modes of practice for providing a setting in which members of the health professions can perform their work effectively and in good heart. They include the suitability of these organizational forms for providing good health care to consumers to the satisfaction of the consumers themselves. And they include the efficiency with which the manpower and other inputs are utilized to produce health care both within each organizational unit itself and — at least of equal importance — within the whole health care system. The full achievement of each of the objectives implied by these considerations may be precluded by some incompatibilities among them. And although on the face of it there does not appear to be any reason why these incompatibilities should be large, there may be some cost in their necessary accommodation to one another.

Some Features of Group Practice in Ontario

The organization patterns of physicians' service in Canada at the present time reveal a broad spectrum of ways of conducting the practice of medicine. In Canada

[1]Canadian Medical Association, *Group Practice in Canada,* Report of the Special Committee on Group Practice, Toronto, 1967, p. 31.

as a whole, solo practice is still the predominant form of practice in communities of all sizes, from small towns to major metropolitan centres. In 1967, solo practitioners accounted for 55 per cent of Canada's physicians, while 14 per cent were engaged in two-man partnerships, and 31 per cent of physicians were engaged in some form of combined or group practice.[2] Group practice is more widespread in the western provinces than in other parts of Canada. But in Ontario, group practice also appears to be gaining a significant degree of acceptance. Table 29.1 indicates that, for more than 8,000 physicians in Ontario responding to the CMA 1967 survey, approximately 25 per cent of physicians practise in groups, 13 per cent in two-man partnerships, and approximately 63 per cent as solo practitioners.

TABLE 29.1

Percentage Distribution of Mode of Practice by Size of Community, All Physicians, Ontario, 1967

	Percentage of physicians engaged in each type of practice		
Size of community	Solo	Two physicians	Group
Under 2,000	70.5	19.5	11.6
2,000- 5,000	56.8	16.7	27.6
5,000- 10,000	53.3	14.3	33.5
10,000- 25,000	61.7	14.8	25.3
25,000-100,000	60.2	15.7	26.2
100,000 central	68.2	8.4	25.0
100,000 suburban	58.6	18.4	25.5
Averages	63.4	13.0	25.3

SOURCE: Research and Planning Branch, Ontario Department of Health, *Survey of the Medical Profession in Ontario,* Tabular Summary, Table XIII, September 1968.

While these figures give some idea of the incidence of group practice, the use of the term itself varies substantially among researchers and writers, and even when it is used in a quite narrow sense, the characteristics of the practices covered by it vary widely. In his study for the Royal Commission on Health Services, Boan defined group practice as "a formal association of three or more physicians providing services in more than one field or specialty with income from medical practice pooled and re-distributed to the members according to some prearranged plan",[3] a definition which Judek used also in his study of medical manpower.[4] The

[2]Medical Manpower Survey, 1967, the Canadian Medical Association, reported in R. D. Fraser, *Selected Economic Aspects of the Health Care Sector in Ontario,* Committee on the Healing Arts, Queen's Printer, Toronto, 1970, Appendix I, Table A24.

[3]J. A. Boan, *Group Practice,* Royal Commission on Health Services, Queen's Printer, Ottawa, 1966, p. 9.

[4]S. Judek, *Medical Manpower in Canada,* Royal Commission on Health Services, Queen's Printer, Ottawa, 1964.

Canadian Medical Association lists five criteria for group practice: 1) at least three duly registered practitioners who 2) practise from a common office, 3) share common records, (4) pool professional income, and 5) distribute earnings on a prearranged basis.[5] It would simply be untrue, however, to claim that there are necessarily significant differences between a solo practitioner with a salaried physician assistant, a two-man partnership, and a three-man group. The Committee recognizes that group practice can take many forms, and we do not limit this discussion to any one particular type.

Groups vary greatly in size. The distribution by size of group of those practices covered by Judek in his survey of the medical profession for the Royal Commission on Health Services is given in Table 29.2. The data given by Judek were for those who responded to a survey questionnaire sent to nearly all physicians in Canada. It is not known how representative the responses were but Judek does not give a reason for their being unrepresentative. It will be seen that in those practices reported in Ontario, slightly over 30 per cent of the physicians were in groups of three; over 50 per cent were in groups of five or fewer. Judek's data also show that group practice was primarily an urban phenomenon, and that those groups that practised in rural areas were small in size.

Groups also vary in many ways other than size. The several forms and varieties of group practice arrangements include general practice groups, single specialty

TABLE 29.2
Number of Groups and Number of Physicians in Each Group Size, by Size of Group, Canada and Ontario, 1962

	Canada		Ontario	
Size of group	Number of groups	Number of physicians	Number of groups	Number of physicians
3	113	339	34	132
4	40	160	10	40
5	26	130	9	45
6	16	96	3	18
7	14	98	3	21
8	3	24	1	8
9	8	72	3	27
10	4	40	1	10
10+	18	360[1]	6	120[1]

[1]An average of twenty practitioners per group is assumed for groups over ten in size; Judek, p. 223, gives a figure of 301 practitioners in sixteen of the groups of more than ten practitioners.

SOURCE: S. Judek, *Medical Manpower in Canada,* Royal Commission on Health Services, Ottawa, Queen's Printer, 1964, p. 360, for number of groups. The number of physicians for each group size is obtained by multiplication.

[5]Canadian Medical Association, *Group Practice in Canada, op. cit.,* p. 8.

groups, multispecialty groups, mixed groups of general practitioners and specialists, and even multidiscipline groups involving non-medical as well as medical personnel. Most groups are physician-sponsored, but industrially sponsored and consumer-sponsored groups also exist in Ontario as well as in other parts of North America.[6] As indicated in Chapter 27, it is also common to find physicians in the larger cities where medical schools are located, practising full or part time in general practice or family practice units based on hospital outpatient or emergency services. The methods of receiving or sharing income also vary quite widely from payment by salary to individual receipt of income from fee for service, accompanied by a contribution to common expenses.[7] The proportion of specialists in groups is higher than that for general practitioners.[8]

No one can say with certainty why groups have developed and flourished in some circumstances and not in others. Some would say that they cannot understand why groups have not become much more common than they are. We do not catalogue their advantages and disadvantages — that has been done elsewhere and frequently.[9] But it is worthwhile dwelling briefly on some of the characteristics of modern health care and particularly, the practice of modern medicine, to see their bearing on the development of groups.

It is not necessary to elaborate that the trends of health care and modern medicine have been towards much specialization among physicians, the use of an increasing variety and number of auxiliary personnel, the use of expensive and elaborate equipment, and the use of large structures for inpatient care. These developments are accompanied by, and indeed are a consequence of, an expanded and expanding base of knowledge and technology. The result has been that there is much more interdependence among the parts now than hitherto, an interdependence that continues to grow. The modern hospital has been one organizational response to these developments. The development of an elaborate system of referral has been another. The growth of laboratories is a third. Undoubtedly, the growth of group practice also can be explained, at least in part, by these developments.[10]

Thus formal groups, if they are of an adequate size and with an adequate diversity of skills, provide one means of adaptation to these changes. They facilitate communication and the application of the knowledge of several persons to one

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[6]See J. A. Boan, *op. cit.*, p. 9 for a discussion of some differences among groups. See also S. Judek, *op. cit.*, pp. 204 ff.

[7]See S. Judek, *op. cit.*, p. 209.

[8]See R. D. Fraser, *op. cit.*, p. 90 Table 6.1 and 6.2. See also S. Judek, *op. cit.*, pp. 207 ff.

[9]R D. Fraser, *op. cit.*, Ch. 6, pp. 89-118 deals with many of the economic features of group practice — and some non-economic features as well. See also J. A. Boan, *op. cit.*, pp. 13 ff. and S. Judek, *op. cit.*, pp. 209 ff. for a cataloguing and some discussion of the advantages and disadvantages of group practice. All three of these writings contain many references to other material on group practice.

[10]Cf. S. Judek, *op. cit.*, pp. 206 ff.

problem. They make possible the ownership and direct use of expensive equipment in the office. They make possible the employment of a wider range of auxiliary help than the solo practitioner could afford. They facilitate the interchange of ideas at work. And they may make it easier than otherwise to provide constant coverage of patients, while at the same time limiting the time that the individual physician needs to be on call. From the patient's viewpoint, they mean that most ambulatory care can be obtained at one place and that the patient's records are in one place.

All of these features of formal group practice are not necessarily limited to such groups. Even the solo practitioner in a geographically isolated office can and does refer his patients to other practitioners, and he may have an arrangement with his colleagues to cover his practice during unavoidable absences. Commonly he has privileges at a hospital. He may have some clerical and technical help in his own office. He also may make use, extensively, if indirectly, of paramedical personnel by having tests done in medical or hospital laboratories, or by referring patients to those with radiological equipment and personnel or to physiotherapists. Despite all these possibilities, however, he must perforce be somewhat isolated from colleagues and assistants.

An appropriate grouping of independent physicians in a medical arts building may be characterized by at least some of the features of the more formally organized group. It will presumably facilitate referral and consultation. A medical laboratory or a radiological unit may be a part of the centre. There may be a considerable interchange of information both about medicine itself and about patients. Some of the advantages of formal groups, which we will note later, may not be achieved but, of course (some people would add), some of the disadvantages may be avoided.

In any event, in much of the subsequent discussion in this chapter, and especially in that part on health centres, our use of the term groups will be in a wider sense than the formal group. It will include those groupings of physicians which facilitate the cooperation of personnel and the cooperative use of facilities that are so much a part of modern health care.

Data collected by Judek throw some light on how groups affect the allotment of physicians' time. Table 29.3 shows the allocation of services and time in 1962 of general practitioners and of selected specialists, in group and in solo practice. Judek's combination of partnership and group practices for those in the specialties makes the data less representative of group practice than if the latter had been shown separately. However, in the case of the general practitioner, for whom partnerships and groups are separated, these two forms of practice have greater similarities to one another than has either to solo practice. The relevant feature of this table is that location of activity of the physician is much more affected by the specialty than by the form of organization. One point of interest is that most of those in groups (or partnerships) tend to have larger parts of their practice in hospitals than do solo practitioners.

TABLE 29.3

Percentage of Average Weekly Services and Time Spent by General Practitioners and Selected Specialists by Type of Activity and Method of Practice, Canada, 1962

	General Practitioner			Anaesthesia		Dermatology		General surgery	
Type of activity	Solo	Partnership	Group	Solo	Partnership or group	Solo	Partnership or group	Solo	Partnership or group
Number of physicians reporting	2,542	819	492	117	225	50	7	364	201
Office calls									
% of total patients	59.8	58.0	57.4	14.3	12.5	75.9	42.1	40.9	48.1
% of total hours	50.3	49.4	49.9	6.9	2.8	71.7	49.0	35.3	39.6
Hospital calls									
% of total patients	21.6	27.9	28.9	85.7	87.5	24.1	57.9	54.6	51.9
% of total hours	19.9	24.6	25.8	80.2	85.9	16.2	29.0	48.0	47.8
Home visits:									
Day									
% of total patients	12.6	8.7	9.0	0.0	0.0	0.0	0.0	4.5	0.0
% of total hours	18.7	14.4	13.1	2.0	0.9	2.0	1.0	3.9	2.7
Night									
% of total patients	3.0	2.9	3.4	0.0	0.0	0.0	0.0	0.0	0.0
% of total hours	5.9	6.4	6.7	1.0	0.0	0.0	2.0	2.0	1.8
Teaching and research									
% of total hours	0.6	0.6	0.5	2.0	5.6	6.1	12.0	4.9	3.6
Other activities									
% of total patients	3.0	2.5	1.3	0.0	0.0	0.0	0.0	0.0	0.0
% of total hours	4.6	4.6	4.0	7.9	4.8	4.0	7.0	5.9	4.5
Weekly number of patient visits per physician	148	179	173	36	38	152	180	115	128
Weekly hours per physician	50	52	52	44	42	43	39	44	44

SOURCE: S. Judek, *Medical Manpower in Canada,* Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, pp. 342-344.

TABLE 29.3 (Continued)

Percentage of Average Weekly Services and Time Spent by General Practitioners and Selected Specialists by Type of Activity and Method of Practice, Canada, 1962

	Internal medicine		Neurology and psychiatry		Obstetrics and gynaecology		Ophthalmology and otolaryngology		Paediatrics	
Type of activity	Solo	Partnership or group	Solo	Partnership or group	Solo	Partnership or group	Solo	Partnership or group	Solo	Partnership or group
Number of physicians reporting	278	137	119	15	274	123	284	62	180	80
Office calls										
% of total patients	38.1	46.2	53.8	36.8	59.1	60.0	76.2	72.0	48.4	41.9
% of total hours	44.8	48.3	60.5	50.8	45.1	48.7	68.8	63.7	38.2	38.2
Hospital calls										
% of total patients	42.9	50.0	38.5	63.2	40.9	36.7	23.8	28.0	31.0	35.5
% of total hours	25.4	28.8	15.8	38.6	38.7	37.8	21.5	27.3	21.2	24.4
Home visits:										
Day										
% of total patients	9.5	3.8	0.0	0.0	0.0	3.3	0.0	0.0	10.3	9.7
% of total hours	8.8	6.8	1.8	1.5	2.7	2.0	1.1	0.0	18.6	17.1
Night										
% of total patients	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.4	3.2
% of total hours	2.6	3.4	0.9	0.0	1.8	1.8	1.1	0.0	7.6	6.5
Teaching and research										
% of total hours	7.0	5.1	9.6	5.3	7.2	4.5	3.2	5.0	6.8	5.7
Other activities										
% of total patients	9.5	0.0	7.7	0.0	0.0	0.0	0.0	0.0	6.9	9.7
% of total hours	11.4	7.6	11.4	3.8	4.5	4.5	4.3	4.0	7.6	8.1
Weekly number of patient visits per physician	110	124	63	90	115	142	110	119	152	147
Weekly hours per physician	49	46	49	52	48	44	40	39	51	48

SOURCE: S. Judek, *Medical Manpower in Canada,* Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, pp. 342-344.

Physicians' and Patients' Attitudes to Groups

We referred earlier to the desirability of having organizational forms that are congenial to the profession as well as having other desirable characteristics. Members of the medical profession see considerable benefit in group practice. Some opinion by the membership of the profession at large in 1962 is reflected in Table 29.4. It is striking that the preponderance of individual medical opinion, aside from that of one large group on one item, appears to be that group practice — and the term group was presumably interpreted in the formal sense in the questionnaire survey that underlay the data of the table — improves the quality of medical services, improves the availability of medical services, and improves the working conditions of physicians. The exception to this view was that the large group of self-employed physicians in private practice were about evenly divided on whether group practice improved the quality of medical services or not. It should be noted that the data of this table do not cover all aspects of group practice and hence do not reflect a comprehensive view of formal group practice by medical practitioners.

The attitude of organized medicine to group practice now seems to be favourable, on the whole. The Ontario Medical Association, in its Brief to the Committee on the Healing Arts, endorsed physician-sponsored group practices as advantageous to both physician and consumer; they expressed concern, however, over consumer-sponsored groups in which "the free choice of physician or patient is restricted".[11] The Canadian Medical Association report on group practices in 1967 also held that "Doctor sponsorship of medical care organizational units or groups is the most desirable pattern of modern medical organization".[12] In their appearance before this Committee, members of the Council of the College of Physicians and Surgeons of Ontario placed particular importance on the value of there being facilities in rural areas so that physicians were gathered in one building.[13]

We must comment on one case of medical opposition to group practice that came to our attention because it may reflect a more widely held attitude. The Committee was informed by physicians in the Sault Ste. Marie Group Health Association — a closed panel consumer-sponsored group — that the local medical practitioners had evidenced considerable overt antagonism to Group Health Association physicians, including denial of membership in the local medical association. The effects of such opposition to prepaid closed panel groups are not as severe in Canada as in the United States, since membership in the local medical association has been necessary for obtaining hospital privileges there, while in Canada hospital

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[11]Ontario Medical Association, Supplementary Brief to the Committee on the Healing Arts, 1968, p. 5.

[12]Canadian Medical Association, *Group Practice in Canada, op. cit.*, p. 30.

[13]College of Physicians and Surgeons of Ontario, Transcript of the Hearings of the Committee on the Healing Arts, July 5, 1967, pp. 5673-5675.

TABLE 29.4

Statistical Analysis of Opinions on Group Practice Expressed by Civilian Canadian Physicians, 1962

Type and auspices of work, duration of practice and size of community in which located	Group practice tends to: Improve the quality of medical services				Improve the availability of medical services				Improve the working conditions of physicians			
	No. reporting	Per cent			No. reporting	Per cent			No. reporting	Per cent		
		Yes	No	Undecided		Yes	No	Undecided		Yes	No	Undecided
Type and auspices of work												
Private practice:												
Self-employed	4,739	46.5	49.9	3.6	4,737	70.1	27.1	2.8	4,860	87.5	10.2	2.3
Partnership	1,428	81.3	17.6	1.1	1,430	91.4	8.1	0.5	1,435	96.1	3.5	0.4
Group practice	1,081	91.0	7.8	1.2	1,069	95.5	3.9	0.6	1,085	98.1	1.5	0.4
Total	7,248	60.0	37.2	2.8	7,236	78.1	19.9	2.0	7,380	90.7	7.6	1.7
Internes and residents	1,064	78.5	18.9	2.6	1,070	88.9	9.5	1.6	1,086	96.6	2.5	0.9
Hospital Staff	951	79.6	17.5	2.9	944	88.0	9.4	2.5	964	96.4	2.2	1.4
Research and teaching	373	72.9	22.3	4.8	377	87.5	11.4	1.1	382	93.2	5.0	1.8
Other	783	77.7	20.3	2.0	788	90.1	8.6	1.3	793	96.1	2.8	1.1
Grand total	10,419	65.5	31.7	2.8	10,415	81.3	16.8	1.9	10,604	92.3	6.1	1.6
Duration of Practice												
Less than 10 years	4,170	65.7	32.3	2.0	4,179	82.7	16.0	1.3	4,245	93.6	5.2	1.1
10–19 years	2,702	62.9	33.9	3.2	2,700	80.7	17.2	2.1	2,754	92.4	6.1	1.4
20–39 years	2,094	63.3	33.0	3.7	2,090	77.6	19.6	2.8	2,133	89.2	8.3	2.5
40 years and over	298	60.7	35.2	4.0	290	71.4	24.5	4.1	293	84.0	12.3	3.7
Size of community in which located												
Less than 10,000 population	1,938	71.7	26.1	2.2	1,919	80.2	17.8	2.0	1,965	93.4	5.0	1.6
10,000–49,999 population	1,251	68.6	28.9	2.5	1,240	81.0	16.7	2.3	1,256	91.6	6.4	2.0
50,000 population and over	7,195	63.2	33.8	3.0	1,223	81.7	16.4	1.9	7,349	92.1	6.4	1.5

SOURCE: S. Judek, *Medical Manpower in Canada,* Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, Table 6.1, p. 213.

privileges are not contingent on such membership.[14] Nonetheless, informal professional and social pressures can be brought to bear upon groups to hinder their establishment and operation. In this particular case we understand, however, that although the Ontario Medical Association did not give direct assistance to those in the Group Health Association in Sault Ste. Marie, it did attempt to soften or contain the conflict and acted in some degree as a moderating influence with the local medical association.

It is not this Committee's function to pass judgment on particular conflicts or disputes. It is our obligation, however, to express our belief that it is quite improper for a voluntary professional association to exert pressure through its own organization, or through other institutions, that inhibits physicians from taking part in such organizational arrangements as consumer-sponsored group practices. If certain organizational arrangements are found detrimental to the good practice of medicine, any corrective action should be taken preferably by the government, but, if not that, by the official licensing and regulatory body with government concurrence. Within this limitation, it is essential that both physicians and consumers be free without hindrance to establish the patterns of practice which they find most appropriate to their circumstances.

As for the patient, there is little systematic empirical evidence in Canada on the attitudes of consumers to forms of organization of practice. More information about one type of group will be available in Canada when the study of the Sault Ste. Marie Group Health Association by Drs. J. E. H. Hastings and F. D. Mott of the School of Hygiene, University of Toronto, is available. Studies made in the United States have shown that most patients are satisfied with the kind of patient-physician relationship possible in group practice, although some patients have expressed preference for the type of one-to-one relationship they see themselves as having with the solo practitioner. It can be argued, quite persuasively,

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[14]In the United States, by 1959 the House of Delegates of the American Medical Association adopted the conclusions of the Commission of Medical Care Plans and endorsed the consumer's free choice of either physician or medical plan; however, there was not a general endorsement of direct service plans or closed panel practice (Somers and Somers, *Doctors, Patients and Health Insurance,* The Brookings Institution, Washington, D.C., 1961, pp. 107 and 341. "Closed panel" practice requires that the patient who receives his service from the plan can choose only from the physicians participating in the practice.) Before that date a number of legal defeats had been suffered by the American Medical Association, and by state and local medical societies, in their attempts to prevent physicians practising in closed panel groups. In 1943, for example, the United States Supreme Court decided that the American Medical Association and the District of Columbia Medical Association had violated the Sherman Anti-Trust Act and had conspired "in restraint of trade or commerce" by expelling physicians practising in the Group Health Association, a non-profit cooperative organization, from local societies and using the power of the societies to deprive the physicians of hospital privileges. (*American Medical Association v. United States,* (1943) 317 U.S. 519; 63 S. Cf. 326.) Although recently the American Medical Association has adopted a more moderate view towards group practices, many local medical associations still display open hostility towards physicians working in consumer-sponsored group practices. In Bellaire, Ohio, for example, group practice physicians were refused hospital privileges and membership in the local medical society until the matter was settled in their favour by arbitration in 1966. (*Public Health Economics,* No. 1966, pp. 797-798.)

that the well-organized groups assume a high quality of patient care at the same time that they assure continuity of services. Moreover, the patient may retain his personal relationship with his physician, by having one member of the group as his primary physician.[15] But the most that can be said now, perhaps, is that group practices continue to grow and to spread, which would not likely be the case if there were not considerable numbers of patients prepared to belong to them.

We turn now to look at the bearing of some of the characteristics of both formal groups and informal groupings on the recommendations we make in other parts of this Report. These characteristics are, first, those that have a bearing on the general milieu in which the physician works and, second, those related to the efficiency of the whole system of providing medical care.

Group Practice and the Physician

Maintaining Continuing Competence

We have commented at some length in the chapters on the individual professions and in Chapters 25 and 26 on the need for various members of the senior professions to maintain their competence; and we have made a number of recommendations towards this end. The importance of daily associations of the physician with his colleagues in maintaining such competence is clear. We have commented on the role in this regard of association with others in hospitals in Chapters 7 and 27. The importance of such association in non-hospital practice also has been made evident to us in briefs presented to us, in our hearings, and in the literature.[16]

The benefits of such association are greatest no doubt in the large formal group; but they can still be substantial in the informal grouping. Information pertinent to this matter was obtained in the Canadian Medical Association study on group practice in 1967 and is reproduced in Table 29.5. The figures speak for themselves. The high proportion of groups having frequent consultations and promoting postgraduate study is especially notable. Data for the United States indicate similar characteristics for groups there.[17] The significance of these arrangements is heightened by the long work week of the physician, which limits time for study.[18]

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[15]See R. D. Fraser, *op. cit.*, pp. 91-93, for an elaboration of this point. See also K. F. Clute, *The General Practitioner,* University of Toronto Press, Toronto, 1963, for some of the shortcomings he found in solo practice of general practitioners in Ontario.

[16]See especially College of Physicians and Surgeons of Ontario, Transcript of the Hearings of the Committee on the Healing Arts, July 5, 1967, pp. 5637 ff.

[17]See R. D. Fraser, *op. cit.*, p. 106.

[18]It is not clear just what the length of the physician's work week is. Some studies report unbelievable hours. But all report very long hours. For hours in Canada in 1967 obtained in the Canadian Medical Association study of 1967, see R. D. Fraser, *op. cit.*, Table A21, p. 247. See also Chapter 30 of this Report.

TABLE 29.5

Quality of Care Procedure in Groups, 1967

Features of groups	Data for Ontario		Data for Canada	
	No.	%	No.	%
Total number of groups	67	100	246	100
Member selection	64	96	240	98
Supervision of new members	55	82	204	83
Clinical conferences	33	49	151	61
Frequent consultations	65	97	239	97
Postgraduate study	62	93	226	92
Reference library	41	61	160	65

SOURCE: Canadian Medical Association, *Group Practice in Canada,* Report of the Special Committee on Group Practice, Toronto, 1967, p. 26. Cited in R. D. Fraser, *op. cit.,* Ch. 6, Table 6.12.

The maintenance of competence is, of course, a prime factor in the maintenance of a good quality of care; consequently, it is of great importance to the patient. We do not need to repeat Clute's findings about the undesirably low standards of care in some of the practices he examined.

Groups and Working Conditions

A second feature of group or combined practice is that it can improve working conditions of physicians. The data of Table 29.4 show that more than 90 per cent of physicians believe such to be the case. That the physician's work week is, on the average, exceptionally long requires little documentation. The Canadian Medical Association medical manpower survey in 1967 indicated that Canadian physicians average in excess of sixty hours per week;[19] the figure for Ontario physicians was 61.3 hours.[20] Judek's data for 1962 record a somewhat shorter work week but one that is still much longer than average.[21] Judek's data also show that in 1962 a substantial part of the physician's work time was on Saturday and Sunday.[22] In addition, there is the fact that patients may seek care around the clock as well as throughout the week and the year. While the resulting problems are great for many specialists such as internists, paediatricians, obstetricians and even surgeons, they are particularly severe for the general practitioner.

In a world in which the work week in general is becoming shorter and holiday time longer, it must be only a matter of time until the work week and work year of physicians are ordered to make working time more regular than it has been, to

[19]See R. D. Fraser, *op. cit.,* Table A.21, p. 247.

[20]Ontario Department of Health, Research and Planning Branch, *Survey of the Medical Profession in Ontario,* Tabular Summary, September 1968.

[21]S. Judek, *op. cit.,* pp. 173 ff. and pp. 342 ff.

[22]*Ibid.,* p. 176. See also R. D. Fraser, *op cit.,* p. 95.

provide more free days, and to reduce time on call. And one would expect ultimately shorter working hours also. Formally organized groups, if of a sufficient size, are best suited for setting up rosters to provide continuous availability of care to patients, while at the same time permitting more free time in evenings or free days throughout the week and year to individual practitioners. Less formal groupings of physicians also may facilitate similar types of arrangements, although they may be less adequate than in the formal group.[23]

We regard the improvement of working conditions as being most important. Such improvement is especially necessary for the general physician if he is to survive. The particular problems of the general physician are examined at greater length in Chapter 30. Here we merely note that the expansion of forms of combined practice appear very important for the improvement of the position of the general physician.

There are, of course, other aspects of working conditions that are important. We have alluded already to the contributions of groups to maintenance of continuing competence. At this point we wish merely to note how groups may affect the physician newly setting up a practice.

In his survey in 1962, Judek obtained information from physicians establishing both general and specialist practices after 1956, about their method of entering practice. The results, which covered 615 solo practitioners and 375 physicians in group practice in 1962, are reproduced in Table 29.6.[24]

A number of interesting points may be gleaned from this table. Of the 615 solo practitioners, nearly 80 per cent had established a new practice and about 16 per cent had taken over existing practices. Of the 375 reporting physicians in group practice, approximately 80 per cent had started their practice under the auspices of a partnership or group. Moreover, as Judek puts it,

> It appears also that the tendency to move from solo practice to group practice is stronger than the opposite tendency. Out of 375 reporting physicians in group practice, 77 or 20.0 per cent gravitated from solo to group practice, while only 19 doctors or 3.0 per cent of the total 615 in solo practice in 1962 started their professional career under the auspices of group practice.[25]

Two benefits of starting in group practice may be noted. First, it will be seen from Table 29.5 that most groups give supervision to new members, and that there are frequent consultations and clinical conferences. Second, one would expect that a physician starting in a group practice would build up his clientele more rapidly than one in solo practice.[26] A considerable part of these benefits might be expected in the less formal grouping in a medical arts building or similar setting.

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[23]See R. D. Fraser, *op. cit.*, pp. 95-97.

[24]S. Judek, *op. cit.*, pp. 245-247.

[25]*Ibid.*, p. 247.

[26]These two points are not meant to be an exhaustive statement of the benefits or disadvantages of starting practice in a group; they are selected because they are undoubtedly important for the new practitioner.

TABLE 29.6

Methods of Establishing Practice by Physicians in Solo Private Practice and by Physicians in Group Practice, by Type of Major Work and Size of Community, Canada, Since 1956

Type of major work and size of community of present practice	Solo private practice Methods of establishing practice					Group medical practice Methods of establishing practice				
			Starting practice under contract with					Starting practice under contract with		
	Taking over practice	Establishing new solo practice	Community organization	Partnership or group	Total	Taking over practice	Establishing new solo practice	Community organization	Partnership or group	Total
General practitioner										
Rural areas	29	42	3	3	77	10	3	—	25	38
Urban areas—under 10,000 population	18	28	1	—	47	5	3	4	30	42
10,000–100,000	22	69	—	1	92	4	8	2	63	77
over 100,000	21	86	—	5	112	1	14	—	39	54
Total	90	225	4	9	328	20	28	6	157	211
Specialist										
Rural areas	—	1	—	1	2	—	—	—	2	2
Urban areas—under 10,000 population	2	7	1	—	10	—	1	—	4	5
10,000–100,000	6	84	2	3	95	1	7	—	41	49
over 100,000	4	163	7	6	180	1	19	1	87	108
Total	12	255	10	10	287	2	27	1	134	164
Total										
Rural areas	29	43	3	4	79	10	3	—	27	40
Urban areas—under 10,000 population	20	35	2	—	57	5	4	4	34	47
10,000–100,000	28	153	2	4	187	5	15	2	104	126
over 100,000	25	249	7	11	292	2	33	1	126	162
Total	102	480	14	19	615	22	55	7	291	375

SOURCE: S. Judek, *Medical Manpower in Canada,* Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, p. 246.

In leaving the subject of working conditions in group and solo practice we realize we have been highly selective in the points we have raised. This selection was purposeful since we believed the issues raised were most important. Some other aspects of working conditions will arise incidentally in the discussion of other points in the remaining part of the chapter.

Medical Records and the Computer

We have commented on the importance of medical records in Chapter 8 and we do not repeat what we said there. Here the advantage of the formal group is clear.

A related recent development is the use of the computer both for handling and evaluating medical records and for business purposes. Whether its uses in private practice can justify its costs are not yet certain, but it is clear that its use is more apt to be an economical proposition for a considerable number of practitioners associated in one place than for an individual in isolation.

Some Economic Aspects of Group Practice

We turn now to two aspects of the economic consequences of group practice: first, its bearing on the use of paramedical personnel; and second, its effects on hospital utilization.

The Use of Auxiliary Personnel

There are various implications for economic efficiency of the significantly greater use of paramedical personnel in group practice than in solo practice. But before examining them we should look at some of the facts. Again we resort to data collected by Judek of which a summary is presented in Table 29.7; these results were based on returns from 1,940 solo general practitioners, 1,889 solo specialists and 953 physicians in groups. Boan surveyed also six selected groups separately for the Royal Commission on Health Services. He found the total number of employees

TABLE 29.7

Number of Nurses, Technicians and Clerical Personnel Employed per Physician in Group Practice and in Solo Practice, Canada, 1960

Categories of employees	Group practice	Solo practice	
		General	Specialist
Nurses	0.5	0.3	0.3
Technicians	0.4	0.05	0.07
Clerical and other	1.0	0.4	0.5
Total employees	1.9	0.8	0.8

SOURCE: S. Judek, *Medical Manpower in Canada,* Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, p. 243 as rearranged in J. A. Boan, *Group Practice,* Royal Commission on Health Services, Queen's Printer, Ottawa, 1966, p. 27.

per physician in these six groups to be 0.41 nurses, 0.32 technicians and 1.43 clerical help for a total of 2.17 employees per physician.[27] The Canadian Medical Association Committee on Group Practice, in 1967, found the number of auxiliary staff per physician in groups to be 2.5 persons.[28] The results show clearly that physicians in groups employ more of all three types of personnel recorded than do solo practitioners.

These data may be compared with data on estimates of numbers of patient-visits and services rendered per physician by specialty and by type of practice, in 1962, given in Table 29.8. In general the number of patient-visits and specific services reported per physician by those in group practice considerably exceed those for solo practitioners; there are some exceptions, however — that of paediatrics is the most notable. Since the data of Table 29.8 were calculated on the basis of reports of a day's activity in the spring of 1962, they must be used with caution. However, they do suggest a higher productivity per physician in group practice, which would be expected from the larger use of paramedical personnel.

Undoubtedly the substantial use of nurses and of clerical personnel in group practice would free the physician of considerable relatively routine work, the nurses by helping with patient care and patient records, and the clerical staff with a great number of office chores.[29] The physician's time should have been correspondingly more effectively used.

Unfortunately, the data on expenses per physician collected by Judek are not given in a way to permit precise comparison between costs of auxiliary personnel per physician in group and in solo practice. His data, which are for 1960, showed average expenses of responding physicians in group practice at $11,350, physicians of solo specialists at $7,890 and of solo general practitioners at $7,450. Most of the higher expenditures in groups appear to be accounted for by higher assistants' fees, higher office rental and higher miscellaneous expenditures.[30]

It is more difficult to assess the implications of the greater use of technical personnel by groups — as distinct from nursing and clerical personnel — than by solo practitioners. As we noted earlier, solo practitioners have access to the services of technical personnel by such means as sending work to private laboratories. Insofar as the technicians in group practices are performing ordinary laboratory functions that would otherwise be done in hospital or commercial laboratories, they are simply providing a service that is otherwise available, although perhaps not in the most convenient location. However, the proximity of the services alone will facilitate better use of the physician's time.

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[27]J. A. Boan, *op. cit.*, p. 27.

[28]Canadian Medical Association, *op. cit.*, p. 24.

[29]R. D. Fraser, *op. cit.*, pp. 97-101 cites the substantial medical time that may be saved.

[30]S. Judek, *op. cit.*, p. 238. Miscellaneous expenses included "convention expenses, association fees, miscellaneous office expenses, etc.". The assistants' fees presumably were for services provided by persons other than the employees given in Table 29.7. See also R. D. Fraser, *op. cit.*, Table 6.7, p. 100.

TABLE 29.8

Estimated Annual Patient-Visit Loads of Physicians in Private Practice and Volume of Services Rendered, Canada, 1962

	Estimated annual patient-visit loads of reporting physicians on the assumption of 48 weeks working year, Canada, 1962		Estimated annual examinations and specific services performed by reporting physicians on assumption of 48 weeks working year, Canada, 1962	
Specialty practised	Solo	Partnership or group practice	Solo	Partnership or group practice
Anaesthesia	1,728	1,824	1,344	1,824
Dermatology	7,676	8,640	3,168	4,320
General surgery	5,520	6,144	1,824	2,064
Neurosurgery	5,520	4,800	1,584	1,824
Orthopaedic surgery	7,008	7,776	1,824	1,824
Internal medicine	5,280	5,952	1,824	2,496
Psychiatry	3,024	4,320	2,584	2,584
Obstetrics and gynaecology	5,520	6,816	2,736	3,168
Ophthalmology and otolaryngology	5,280	5,712	3,168	3,168
Paediatrics	7,296	7,056	4,128	3,408
Urology	5,280	5,952	2,064	1,824
General practice	7,104	8,592-8,304	2,688	

SOURCE: Adapted from S. Judek, *Medical Manpower in Canada,* Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, p. 184.

Comparative capital costs of office and other space and of equipment in group and in solo practice are also relevant. We merely note that Judek's data show a lower average amount of capital assets used by reporting physicians in group practice,[31] a lower average annual depreciation allowance[32] and a lower expenditure on purchase of new buildings or equipment per reporting physician.[33] The implication is drawn that there is an economy in sharing buildings and equipment in group practice.[34]

The meaning of all this for physicians' incomes is, of course, important. Here again the situation is not entirely clear. Judek's data show that for Canada as a whole the average net income from medical practice and salaried appointments of reporting physicians was $19,420 for physicians in partnership or group practice,

[31] S. Judek, *op. cit.,* p. 244.

[32] *Ibid.,* p. 238.

[33] *Ibid.,* p. 245.

[34] *Ibid.,* p. 244. See R. D. Fraser, *op. cit.,* pp. 101-105, for an extended discussion of this matter.

$18,730 for specialists in solo practice, and $13,820 for general practitioners in solo practice; the comparable data for Ontario were $18,890 for physicians in partnerships or groups, $20,660 for solo specialists, and $14,930 for solo general practitioners.[35] Clute's calculations for a small number of Ontario physicians in 1955 or 1956 are given in Table 29.9; they clearly indicate a higher income for physicians in groups.

TABLE 29.9

Median Net Professional Incomes per Hour of Work of Ontario Physicians with Various Types of Practice Arrangement, 1955 or 1956

Type of practice	Number of physicians	Median net hourly-income
Solo, without nursing or secretarial assistance	9	4.19
Solo, with nursing or secretarial assistance	19	5.17
Group of two, with assistance	8	6.09
Group of more than two, with assistance	6	8.17

SOURCE: K. F. Clute, *The General Practitioner,* University of Toronto Press, Toronto, 1963, p. 194, cited in R. D. Fraser, *Selected Economic Aspects of the Health Care Sector in Ontario,* Committee on the Healing Arts, Queen's Printer, Toronto, 1970, Table 6.8.

Group Practice and Hospital Costs

The other important economic aspect of group practice with which we deal is its relationship to the use of hospitals. One might expect that those patients who obtain their care from groups would have less need for hospitalization than those receiving care in other ways, since — at least in large multispecialty groups — they could obtain a more substantial range of diagnostic services, and perhaps also more preventive care, than could be readily supplied by more isolated practitioners. Such evidence as there is appears to bear out this expectation. About the only information we have for Canada is that for the Sault Ste. Marie and District Group Health Foundation. Data for 1964 were submitted to us by this group which showed that there were ninety-six admissions to hospital per 1,000 population and 680 days of care per 1,000 population in the group compared with 136 admissions and 1,497 days care per 1,000 population for the Sault Ste. Marie region at large.[36] The membership of the Sault Ste. Marie Group appears to have a slightly smaller proportion of the elderly than the general population of the area, but that circumstance could account for only a small part of the difference.

There is a substantial amount of information for the United States. Data for the Kaiser Foundation plan in California show much reduced use of hospitals by

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[35]S. Judek, *op. cit.,* p. 221.

[36]Sault Ste. Marie and District Group Health Foundation, Brief to the Committee on the Healing Arts, 1967, given in R. D. Fraser, *op. cit.,* p. 109.

their physicians who practise in groups.[37] In this case, there are built-in incentives to reduce hospitalization because many hospitals operate as a part of the plan, and the physician's income may be reduced by unnecessary hospitalization. Other data for the United States, much of them also for prepaid plans, however, show the same result.[38]

With hospital costs having become very high indeed, it is important that alternative means of providing appropriate care at lower cost be developed. It would be expected that the saving of hospital use by means such as those that have been associated with group practice would mean a net reduction of cost to the community — or, in other words, that the cost of the extra diagnostic and preventive care given by the groups would be less than the resulting saving in hospital cost. However, the studies have not analyzed what the lower hospitalization associated with groups means for the combined cost of hospital and non-hospital care. Such studies would be most worthwhile.

Health Centres

Health centres or community "clinics" may take many different forms. One of the most recent developments in the provision of health services, although yet in its infancy, is the emergence of the community health centre. In one sense, it may be regarded as a logical extension of previous organizational patterns for the provision of ambulatory care. There has already been a growing emphasis on the use of hospital outpatient departments, clinics, and especially emergency department services for ambulatory care. With the growing acceptance of group practice arrangements, both hospital based and non-hospital based, some students of health care believe that the next step in organizational innovation may be establishment of multi-discipline health centres with combined facilities for the provision not only of physicians' services, but the services of various paramedical personnel and other professional healers as well.

In its most highly developed form, this comprehensive system of practice combines preventive and curative medical practice, the services of specialist nurse practitioners, paramedical personnel, and other health workers such as chiropodists, optometrists, medical social workers, psychologists, and public health personnel. Although this organizational pattern has had little application in Canada as yet, it is a flexible and promising pattern of care which the Committee believes could be experimented with in Ontario.

In the United States, neighbourhood or community health centres have sprung up in many areas during the past decade, although some of them are of a special type that may have limited relevance for Ontario. Centres of this type have been established in a number of poverty areas under the sponsorship of the American Federal Office of Economic Opportunity; some have been established through

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[37]R. D. Fraser, *op. cit.*, p. 63.

[38]See *ibid.*, pp. 106-111, for an extended discussion and more evidence on this matter.

initiatives taken at the state or local levels. Institutions such as the Columbia Point Health Centre in Boston, the Montefiore Neighbourhood Health Centre in New York, and the South Side Neighbourhood Clinic in Chicago are experimenting with different patterns of health care services, emphasizing the concept of the integrated "health care team". Operated on the assumption that health care should be comprehensive and environmental rather than fragmentary and episodic, and should be geared to the specific needs of an individual community, and located in the midst of disadvantaged urban or rural populations which have previously lacked direct access to high quality health care, the centres provide twenty-four hour service and take responsibility for the total care of individuals in the community, including home care programs and public health work.

Most of the neighbourhood health centres in the United States, sponsored by the Office of Economic Opportunity, are a special type of health centre, for they are heavily subsidized and represent attempts to reach certain underprivileged groups as part of the anti-poverty program. And they are still experimental. But other forms of community health centres are being established in the United States, including some organized and operated entirely by private physicians.

The concept of the health centre is a flexible one, adaptable to a wide variety of situations and modes of organization. One cannot draw a clear-cut distinction between some group practices and health centres. Some large multispecialty or multidiscipline groups appear to provide the kind of comprehensive care envisaged by proponents of the community health centre concept. Under a variety of organizational forms, the participating physicians and other health professionals can be part of a group, or be associated on an individual basis, work full time or part time in combination with hospital or solo practice, and be paid on a fee-for-service or salary basis. Various combinations of professional and occupational skills and disciplines can be brought together to meet local needs. In association with university medical schools, schools of health sciences, and teaching hospitals, health centres may provide unique clinical opportunities for teaching medical and other healing practitioners, as well as opportunities for multiphasic screening and preventive health programs, public health education, mental health care, and continuous research into patterns of patient care.

Then, too, health centres, as well as certain types of group practices, often include in their organizational structure elected committees of users or patients so that the consumer of health services may have a voice in formulating the policies and practices of the institution. Patients' committees can have many uses. They can express opinions and make requests, raise questions, express grievances, provide "feed-back" to practitioners relating to services rendered, and perform a helpful liaison function between the professions and the layman.

Admittedly the concept of the community health centre is relatively new, but it seems clear that the concept is becoming more widely accepted in several jurisdictions. The *Report to the President on Medical Care Prices* in the United States,

for example, helped to popularize the concept of integrated clinics and urged that "comprehensive community health care systems should be developed, demonstrated, and evaluated".[39] The *British Royal Commission on Medical Education*[40] envisaged a network of multidiscipline health centres, fully equipped for routine diagnostic procedures, providing most forms of ambulatory care, and including public health facilities. Nor are community health centres in the United States any longer considered only as innovations designed exclusively for use in areas of poverty. In a recent paper, the immediate past president of the American Medical Association has indicated the growing acceptance of such centres, their more general applicability to health care problems, as well as his belief that "in one form or another the community health centre will become one of the most important health facilities and, next to the hospital, perhaps the most important. It should be studied very carefully by the medical profession . . . . Clearly in such centres care can be rendered less expensively than in hospitals . . . . We must relieve ourselves of the concept that they are facilities primarily for welfare, social, and recreational functions only. I stress their value in preventive, diagnostic and curative medical services."[41]

A role may be seen for health centres varying from the comprehensive kind, which has just been described, to the limited centre or clinic. One does not need to think of them as precluding other forms of provision of health care where they exist. The Committee was particularly impressed during its hearings by the value placed on the existence of centres for medical care in rural areas by some members of the Council of the College of Physicians and Surgeons of Ontario.[42] If they proved to be attractive places for physicians to practise, as it was suggested they might, at the same time that they provided high quality health care for rural areas, they would do much to solve the problem of providing care in rural and sparsely populated areas. Supplementation by satellite clinics making some use of the skills of nurse practitioners and other paramedical personnel could prove useful in the most remote areas. Some group practices already have opened satellite offices in rural areas and small towns where patients can be seen locally at regular times, without having to travel to the base location of the practices. Such centres could prove to be of value in particular parts of urban centres as well.

Conclusion

A trend towards formal group practice and less formal groupings of physicians seems evident. Yet the extent of the development should not be exaggerated. Many

[39]John W. Gardiner, *A Report to the President on Medical Care Prices,* Department of Health, Education and Welfare, Washington, February 28, 1967, p. 4.

[40]*Report of the Royal Commission on Medical Education, 1965-1968,* Cmnd. 3569, Her Majesty's Stationery Office, London, 1968, p. 34.

[41]D. L. Wilbur, M.D., "Clinical Sense, Social Sense, Common Sense", *Journal of the American Medical Association,* Vol. 209, No. 5, August 4, 1969, p. 683.

[42]College of Physicians and Surgeons of Ontario, Transcript of the Hearings of the Committee on the Healing Arts, July 5, 1967, pp. 5624, 5673-5675.

groups are still small in size and do not have all the characteristics of the full-blown group. The solo practitioner is still dominant in numbers among physicians in private practice, and that there will be many in this traditional form of practice for years seems likely. Nevertheless, the organizational structure for providing health care continues to evolve. The development in hospitals of what is really a combined form of practice — and much more besides — has gone far in the last fifty years. Adaptations in forms of organization outside hospitals appear to have lagged substantially. That there will be considerable further adaptation in the organization of the private practice of medicine seems probable as the knowledge and technology of medicine continues to grow in complexity and as interdependence among practitioners in the healing arts continues to increase.

The Committee's recommendations in this chapter are made in the view that group practice, of both the formal and informal kind, carries considerable promise in this process of adaptation — and the groups may well include many more disciplines than just that of medicine. They are designed, then, to facilitate the development of group practice, insofar as it proves to be a viable form, without trying to impose an organizational structure that is not agreeable to either patients or practitioners. Our recommendations concern education, research into group practice, removal of legal, institutional and financial inhibitions to group practice, and the provision of financial and other help.

We have noted, especially in Chapters 8 and 30, that the clinical part of education in medical schools has tended to be centred about hospital experience. The reasons for this characteristic of education have been very good ones, not the least important of which is that teaching hospitals are where the best medicine is practised. Nevertheless, as we note in Chapters 8 and 30, there is much to be said for the medical student being exposed to the problems and modes of private practice during his period of education. Such exposure should include experience with group practices.

Recommendation:

344 That medical faculties in Ontario include in their curriculum and during the internship period opportunities for students to work with different kinds of practice outside hospitals, including group practice and that medical schools should include information about forms and problems of practice as a part of the curriculum.

It is apparent from the earlier part of this chapter that relatively little is known about many aspects of group practice. For example, knowledge of how the incomes of those in group practice compare with those in solo practice is limited. What is needed is more than just averages of incomes in different kinds of practice; we should also know how the incomes of individual specialties and of general practitioners compare as between different practice settings as well as much more. We should know more about relative costs of practice by components of expense.

There should be studies in depth of the relationship of different forms of practice to hospitalization costs. And one could extend greatly this list of things to be examined. We believe it highly important that further and extensive studies of patterns of practice be done immediately. Moreover, the information that is obtained should be made widely known.[43]

Recommendation:

345 That the Department of Health and the Ontario Council of Health undertake, promote, and finance research into group practice including studies of comparative use of paramedical personnel, comparative incomes and expenses of physicians in groups and other practices, the relationship of practice in groups to the cost of hospitalization, and many other such matters.

We have noted that groups are featured by a larger use of paramedical personnel than common in other forms of private practice. As we have indicated in Volume 2 of our Report and as is shown in some of the studies done for us, new types of paramedical personnel continue to emerge. Along with this characteristic of medicine is the fact that existing types of auxiliary personnel may not have been used for some functions which they might properly perform. We do not know to what extent present regulatory legislation, formal regulations made under the legislation, and other features of the regulatory apparatus have hindered the delegation of functions that could be delegated appropriately to auxiliary personnel. That there has been some hindrance seems certain. And even if it is only small — and, as we have said, we do not know its magnitude — it still forms a barrier to the rational use of auxiliary personnel.

The methods and criteria of payment for health services under health insurance plans to those in private practice is another matter that may affect organizational patterns of practice. It is important that the mode of payment not hinder the continuation and perhaps further development of the variety of methods of payment for medical services and determination of income in various forms of combined practice. The method of reimbursement for services may also affect the use of auxiliary personnel; if the services of auxiliary personnel are covered in one setting, they should be covered, at least in most cases, in other settings where similar types of services are being provided.

Recommendation:

346 That the Department of Health see that arrangements for payment for services under publicly financed health insurance plans are such as not to hinder the development of group practice of various organizational structures and using various types of auxiliary personnel; and that the

[43]Boan's contention that lack of knowledge of group practice among practitioners is one of the obstacles to group practice appears reasonable. J. A. Boan, *op. cit.*, p. 43.

Department of Health take steps on its own or in collaboration with regulatory bodies to see that legislation, formal regulations, and other features of the regulatory apparatus, do not hinder appropriate assignment of functions to auxiliary personnel.

While we have not studied in depth the problems of making provision for health care in underserviced rural areas, villages and small towns, or for that matter in some parts of cities, the existence of shortage of services in many areas has come to our attention. There are now the provincial programs, described in Chapter 8, which provide financial incentives to physicians and dentists to practise in underserviced areas. We have discussed, in this chapter, the possibility of the development of health centres from which a number of members of medical and other independent professions, along with appropriate auxiliary personnel, might practise. It is in the rural and isolated areas that practice in groups or in groupings can help most to reduce isolation and improve working conditions.[44]

In general, we are not aware of a financial problem of obtaining capital for establishment of the buildings and other facilities necessary for group practice;[45] the problem may be more one of obtaining entrepreneurship than capital.[46] However, in non-urban settings and especially in sparsely settled areas, the problem of obtaining capital (and entrepreneurship) may be very real.[47] In these areas the alternative uses for a "clinic" building, should the centre not prove viable, are not as great as in urban areas. Further, practitioners may spend shorter periods of practice in such areas than in urban communities and may not wish to be involved in problems of financing buildings and facilities. We believe that provincial assistance in the financing of health centre facilities in non-urban areas is well justified. If other forms of assistance in problem areas, such as those now in force, are necessary, there is no reason why they also should not be available to those in health centres.

We have not elaborated on the means of providing financial assistance for the establishment of health centres. There is much experience elsewhere on which to draw. We do believe, however, that regional or local involvement in the provision of such assistance is desirable.

In stressing assistance to groups or health centres in non-urban areas we do not mean to preclude the possibility of assistance to groups in other circumstances. Somewhat similar help may be appropriate in certain parts of urban communities. In addition, it may be desirable to provide financial or other help to groups that are attempting what appear to be promising adaptations in the delivery of health care.

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[44]See J. A. Boan, *op cit.*, Ch. 4, pp. 37ff. for a discussion of group practice in non-urban communities.

[45]See J. A. Boan, *op. cit.*, pp. 44-46.

[46]*Ibid.*, p. 44.

[47]*Ibid.*

Recommendation:

347 That the Department of Health provide inducements, where appropriate, for the development of group and related kinds of practice, such inducements to take the form of financial assistance for the establishment of group or health centre facilities in remote or underserviced areas and, if necessary, further subsidization of these practices; financial assistance for research related to uses of paramedical personnel; and financial help to pilot projects in which new modes of group or combined practice are being tried.

Chapter 30 The General Physician

We have heard and read a great deal about the "problem" of the general practitioner. The declining numbers of such practitioners, relative to the number of specialists, is well documented, not only in Canada, but in the United States and in many other western countries as well. We cite some of the evidence later in this chapter. At least some part of this decline in relative numbers of general physicians is to be expected for reasons to which we alluded in our earlier discussion of the medical profession (Chapter 8). In a technologically oriented society in which specialization of skills is associated with the expansion of knowledge and of the scope of medical practice, it is not surprising that medicine has shared with other professions a strong shift towards specialization. There are some who appear to believe that the advantages of specialization are so great that the general physician is obsolete, and that whatever coordination of medical care is required by the patient can be provided by the further development of large hospitals and other institutions in which groups of specialists might work;[1] but the more common opinion, as we discern it, is that there is a continuing role for a generalist.[2]

The Committee has examined the role of the general physician with care. In addition to our broad study of the health care system, we have had the benefit of our hearings; we have considered the very extensive literature on the role of the medical generalist, and our own staff internally prepared a lengthy research paper surveying this literature. Of necessity, we have had to place considerable weight upon the opinion of experts in this matter. We found a strong consensus here. The preponderance of scholarly medical opinion holds, quite clearly it seems to us, that the decline in the number of people whom we may call generalists, or who might alternatively be called personal or family physicians, has gone so far

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[1]For example, see George Silver, "Beyond General Practice: The Health Team", *Yale Journal of Biology and Medicine,* September 1958.

[2]See J. W. Grove, *Organized Medicine in Ontario,* Committee on the Healing Arts, Queen's Printer, Toronto, 1969, pp. 6-7, for the results of three surveys of the public — one in Hamilton, Ontario, and two in Britain — in which the preponderance of opinion was that patients preferred to receive attention from their "own" physician, who was presumably, in most cases, a generalist of some sort.

The position on the matter by others, and particularly those in the medical profession, is elaborated in greater detail later in this chapter. At this point, however, we should like to refer to the views expressed to us by the Deans of Medicine in Ontario medical schools. See Ontario Deans of Medicine, Transcript of the Hearings of the Committee on the Healing Arts, May 24, 1967, p. 3279.

as to become a matter of major concern.[3] Not only most medical professionals who have studied the matter, but also several important independent bodies which have examined it appear to agree that there is a role and a need for a medical generalist of some kind.[4] The role of the generalist is seen as being to serve as the point of first contact between the patient and the health care system, to provide much and frequently all of the necessary treatment, to refer to specialists when the need arises, and to coordinate the medical services received by the patient.

We accept the judgments of this body of informed opinion, a view corroborated by our own studies of the health care system, that some such generalist is required. We noted in our investigation of alternative methods of delivering health care that even when group or other private health schemes have been organized to provide medical care using only specialists, some of these "specialists" — frequently the internists — have in fact served as generalists in these arrangements.[5] Indeed, even casual observation of the existing practice of medicine in Ontario reveals that a considerable number of internists, and also others such as paediatricians, obstetricians and gynaecologists, and even general surgeons, do in fact also offer personal or family medical care of a general nature.[6]

There is a generally recognized need for a practitioner who can serve as the patient's contact with the health system, perform diagnoses and provide much of the necessary care himself, refer to others, and coordinate the care received by the patient and, where appropriate, by his family. Such a generalist could conceivably take a number of different forms, however, and we have found that while there is considerable agreement about the need for this person in the health care system, there is less unanimity about what his qualifications should be. Traditionally the role of the generalist has been performed, for the most part, by the general practitioner — the physician with a period of formal training consisting of four years of medical school and one or two years of hospital internship. But, as we have seen, the general practitioner is losing ground rapidly. In what follows we will examine the main evidence on this point; we will then consider the causes of the decline of the generalist and possible avenues of remedial action.

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[3]A decline in the number of general practitioners does not necessarily mean a decline in the quantity of services that typically might be associated with general practice. The development of specialties means that many patients previously treated by general practitioners are now referred to specialists, who are better trained to provide care of the kind needed by those referred to them, thus freeing some of the general practitioner's time. But opinion seems to be that the decline in the number of general practitioners is going too far.

[4]For example, see *The Graduate Education of Physicians,* Report of the Citizens' Commission on Graduate Medical Education, John S. Millis, Chairman, Chicago, 1966; *Report of the Royal Commission on Medical Education,* Cmnd. No. 3569, London, Her Majesty's Stationery Office, London, 1968; *Report of the Royal Commission on Health Services,* Queen's Printer, Ottawa, 1965.

[5]Such is the case with the Montefiore Medical Group in New York City and the Kaiser Medical Group, affiliated with the Permanente Hospital in Palo Alto, California.

[6]J. W. Grove, *op. cit.,* p. 227.

The Decline of the General Practitioner

The British Royal Commission on Medical Education in 1968 reported both an absolute and a relative fall in the number of general practitioners within the National Health Service, a system, significantly, which offers the general practitioner institutional support.[7] The National Advisory Commission on Health Manpower in the United States reported in 1967 that less than 2 per cent of the medical graduates in that country were entering general practice. The Coggeshall report in the same country reported less drastic but still impressive figures; according to this report, at least 85 per cent of medical graduates plan to enter specialized practice.[8] After surveying general practices in various countries, a British physician reported in *The Lancet* that

> The decrease in the proportion of doctors choosing general practice as a career is well documented in every country. This has now become a medical fact of life.[9]

The effect of this "medical fact of life" in Canada as a whole and in Ontario is revealed in the data given in Chapter 8, pp. 49-50. We need not repeat those data here, but merely refer the reader to them.[10] It is perhaps worth giving two additional bits of information. In 1969, of 8,501 physicians in Ontario listed by Seccombe House, 3,388 were recorded as general practitioners, 988 were general practitioners with specialist interests, and 4,125 were specialists. A breakdown of these by major centres and by countries may be found in Fraser's study of the economic aspects of the health care sector in Ontario, commissioned by this Committee.[11] The Ontario Medical Association estimated in 1966, that of 5,000 physicians in Ontario responding to a survey, 54.1 per cent were available to see patients directly, the remainder being in private practice on referral (20.4 per cent), in institutional practice (16.4 per cent), in public health (1.4 per cent), and in administration, research, and so on (7.5 per cent).[12] Presumably some of those seeing patients directly were specialists. An indication of how the medical time of general practitioners and specialists in Ontario is divided between patient care and other duties was obtained in a manpower study of the CMA in 1967. The division of medical time for 8,203 responding physicians in Ontario is given in Table 30.1.

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[7]*Report of the Royal Commission on Medical Education,* 1965-68, op. cit.

[8]L. T. Coggeshall, *Planning For Medical Progress through Education,* prepared for the Association of American Medical Colleges, Evanston, 1965, p. 21.

[9]Michael Drury, "Work Load and the General Practitioner", *The Lancet,* October 14, 1967, p. 823. Quoted in J. W. Grove, *Organized Medicine in Ontario, op cit.,* p. 256.

[10]For data comparing the situation in 1962 with that in 1943, see J. W. Grove, *op. cit.,* p. 253.

[11]R. D. Fraser, *Selected Economic Aspects of the Health Care Sector in Ontario,* Committee on the Healing Arts, Queen's Printer, Toronto, 1970, Table A29 and A30.

[12]Ross Matthews, "Manpower, Demand, and Medical Care", *Ontario Medical Review,* September 1966, p. 650. See also J. W. Grove, *op. cit.,* p. 27.

TABLE 30.1

Percentage of All Medical Time Spent in Patient Care and Other Activities, Ontario, 1967

	G.P.	Specialists	All-doctors
Patient care:			
Fee for service	75.1	60.4	66.6
Salaried	13.9	14.6	14.3
Other activities	11.0	25.0	19.1

SOURCE: Ontario Department of Health, Research and Planning Branch, Survey of the Medical Professions in Ontario, Tabular Summary.

Aspects of the Decline of the General Practitioner

There are two aspects to the relative decline in the number of general practitioners: a falling off of recruitment into general practice, and an exodus of former general practitioners to specialties and other fields. Unfortunately, no trend data exist for either of these aspects, but studies conducted by the University of Toronto and by Stanislaw Judek for the Hall Commission provide figures for one point in time.

The University of Toronto study, conducted in 1965, revealed that twelve of 150 first year medical students intended to enter general practice, and twenty-seven of 103 fourth year students had this intention. Among recent graduates at the same time, eighteen of 115 planned to enter family practice permanently, and an additional thirty-four planned a temporary period of general practice, twenty-nine of these intending to return for specialty training.[13] The University of Toronto probably presents an exaggerated instance of these intentions, but there can be little doubt that the tendency of graduates to shun general practice and enter specialty practice is great.

Judek's figures (see Table 30.2) indicate the extent and the direction of the exodus from general practice. This table may be interpreted as follows. The type of practice first entered by the new physician is shown in the stub on the left (first for Canada and then for Ontario). The figures across the rows opposite the type of first practice given in the left hand stub show in what setting the physician was engaged in 1962 (see the headings on the columns). The first column shows the number of physicians in each case. Thus, reading across, the first row of figures shows that of 4,016 physicians, in Canada, in 1962 whose first practice had been as a general physician, 72.7 per cent remained in general practice, 17.8 per cent were specialists in private practice, 3.1 per cent were specialists in hospitals, and so forth. It may be seen from the data for Ontario that of a sample of 1,510 Canadian-born physicians practising in Ontario, who began their career in private

[13]R. L. Perkin, "Medical Manpower in General Practice" in *Medical Care Insurance and Medical Manpower*, manuscripts of the Canadian Medical Association Conference, Montreal, Quebec, June 19-23, 1967, pp. 95-100.

general practice, 74.2 per cent remained in this field in 1962, a figure to be contrasted with the 92.8 per cent of the specialists who had begun as specialists and who remained in private specialist practice. The figures are similar for immigrant physicians, except for the notably greater proportion of these physicians who leave private specialist practice for specialist positions in hospitals.

TABLE 30.2

Percentage Distribution of Active Physicians, by Type of Major Work of First Practice and Type of Major Work in Which Engaged, Canada and Ontario, 1962

Kind of first practice	Number of physicians	Kind of practice in 1962				
		Private		Hospital		Other
		G.P.	Specialist[1]	Specialist[1]	Other	
Data for all Canada						
Canadian-born physicians						
Private						
G.P.	4,016	72.7%	17.8	3.1	1.2	5.1
Specialist[1]	2,215	1.0	94.2	2.1	—	2.3
Hospital	506	1.0	4.5	75.5	13.8	5.1
Other	729	14.8	20.6	3.3	3.0	58.1
Immigrant physicians						
Private						
G.P.	1,100	75.0	15.7	2.2	1.6	5.4
Specialist	679	1.9	78.4	14.7	—	4.7
Hospital	283	7.4	12.0	59.4	14.1	7.8
Other	440	24.3	13.4	7.7	1.8	52.7
Data for Ontario						
Canadian-born physicians						
Private						
G.P.	1,510	74.2	14.3	3.8	1.1	6.5
Specialist	869	1.3	92.8	2.7	—	2.8
Hospital	173	1.7	4.6	81.5	8.7	3.4
Other	253	13.4	19.0	2.9	1.6	60.5
Immigrant physicians						
Private						
G.P.	436	75.9	16.3	1.8	—	5.3
Specialist	264	1.1	80.7	13.2	—	4.9
Hospital	100	5.0	9.0	63.0	12.0	11.0
Other	153	27.4	14.4	7.8	—	49.7

[1]Judek's "Specialist" and "Consultant" categories were combined for our purposes.

SOURCE: S. Judek, *Medical Manpower in Canada,* Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, Tables 4-13A and 4-13B, pp. 330-333.

Some Causes of the Decline

The reasons for the declining recruitment into, and the exodus from, general practice may be summarized under four heads: working conditions, remuneration, status, and education.

Working Conditions

The prospect of long and irregular working hours, overwork and limited access to hospitals make general practice the least attractive avenue for medical graduates, and the experience of these conditions causes many practising physicians to leave the field. The heavy work load is suggested by Judek's figures, showing an average work week of fifty-two hours for general practitioners. Judek's comparable figure for all specialists was forty-three hours, for consultants forty-four hours;[14] however, it should be noted that some specialists such as internists, paediatricians, urologists and psychiatrists, and orthopaedic surgeons and obstetricians in solo practice worked hours comparable to those of general practitioners.[15] A British Columbia study set the general practitioners' average work week at sixty-two hours; K. F. Clute found it to be 52.5 hours in Ontario and 60.2 in Nova Scotia, exclusive of night calls;[16] and a Hamilton study found the G.P.'s average work week to be 67.4 hours.[17] Thirty-two per cent of Clute's respondents felt they were seeing too many patients.

Clute found, moreover, that professional isolation, both geographical and professional, was considered a disadvantage by many of the general practitioners whom he interviewed. This complaint is related to another one arising from the differential access of general practitioners and specialists to hospital beds and facilities. In 1965 the Ontario chapter of the College of Family Physicians of Canada conducted a survey among its members concerning their problems and attitudes with respect to the hospitals.[18] The survey revealed dissatisfaction among general physicians, particularly in urban areas, with increasing restrictions affecting the general practitioner in the hospital. We dealt with the question of hospital privileges at greater length in Chapter 27. In many cases these restrictions may be justified; indeed most of Clute's respondents did not feel unduly restricted. However, in large urban hospitals, where most dissatisfaction exists, specialists predominate on the Medical Advisory Boards, the bodies responsible for determining hospital privileges, and general practitioners feel that the professional interests of specialists have led to their exclusion.[19] The study by the College of Family Physicians of Canada underlines the existence of

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[14]S. Judek, *op. cit.*, p. 174.

[15]*Ibid.*, p. 342.

[16]K. F. Clute, *The General Practitioner*, University of Toronto Press, Toronto, 1963.

[17]Ross Matthews, *op. cit.*, pp. 651-652.

[18]Reported in "Hospital Committee Reports", *College of General Practice Journal*, February 1966. See also J. W. Grove, *op. cit.*, p. 136.

[19]Data in Chapter 27 show that it is in the large metropolitan centres where the limitations on hospital privileges are the greatest. See Chapter 27, pp. 135-136.

these problems. It indicates that only in smaller hospitals is there "generally satisfactory rapport" between general practitioners and specialists.

Paradoxically, the situation has been most acute in the teaching hospitals where, from one viewpoint, it is the most undesirable. Here the restrictions on general practitioners not only have caused hardship for the practice of the general practitioners of the community but have limited exposure of medical students to the work of general practitioners.[20] The medical schools in Ontario have made a beginning in tackling the problem of exposing medical students to the work of general practitioners; their programs are described later in this chapter.

Remuneration

The general practitioner is not rewarded for these long hours of work and for relative professional isolation by higher income. The physician entering general practice may expect a lower annual and lifetime income than his specialist colleagues. In his study for the Hall Commission, Judek found the average net annual income of specialists in private practice to be almost $5,000 higher than that of general practitioners.[21] In the matter of income, in fact, the general practitioner experiences a double disability. In the first place, where his hospital privileges are restricted, he may have to refer cases that he would otherwise treat, and is qualified to treat, to those who possess appropriate privileges, especially in areas whose community hospital is a teaching hospital. In the second place, his fees as established in the professional fee schedule are lower than those quoted for specialists, even for the same procedures. This circumstance may be justified in some instances but not in others. Although the professional fee schedule is not binding upon any physician, it is assuming increasing importance as the basis for remuneration under medical insurance plans. OHSIP, like its predecessors OMSIP and the private insurance plans, remunerates only certified specialists at the specialist rates set down in the fee schedule.

Professional Status

In a discussion of the declining status of the general practitioner, it must be recognized that, for whatever the reasons, the profession as a whole appears to have lost some prestige in recent years. Ironically, it is the harried general practitioner who has suffered the greatest loss of prestige, not only in the eyes of the public but, probably more importantly, within the profession as well.[22] It has been suggested that the prestige of a profession varies with the length of its training program and thus among professional subdivisions. All specialists have taken the training necessary for general practice,[23] and have progressed to additional train-

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[20] J. W. Grove, *op. cit.*, pp. 137 and 226 ff.

[21] S. Judek, *op. cit.*, p. 222.

[22] See J. W. Grove, *op. cit.*, p. 8, for some of the views expressed by physicians studied by Clute.

[23] Except for the training received by the few recent graduates of the three-year family practice programs discussed later in this chapter.

ing. Hence it is not surprising that many regard general practice not as a different field of medicine, but as an inferior level of medical practice.

The status gap between specialties and general practice is difficult to measure or document, but its undeniable reality has been recognized by numerous official bodies, both professional and lay. In the United States the Citizens' Commission on Graduate Medical Education (the Millis Commission) stated the problem concisely. It found that one of the three major reasons for the "failure to develop a substantial corps of well-trained primary physicians" is the fact that

> General practice, once the mainstay of medicine, had gradually lost prestige as the specialties have risen in honor and accomplishments. In deciding upon his own career, the young physician may never see excellent examples of comprehensive, continuing health care or highly qualified and prestigious primary physicians. He is certain, however, to see a variety of specialists and to observe that they usually enjoy higher prestige, greater hospital privileges, and more favourable working conditions than do general practitioners.[24]

This set of circumstances has led general practitioners' associations to seek a definition of family practice as a unique field in its own right, and to seek specialty status for this field, a movement which is discussed in greater detail below.

The Educational Milieu

The claim is often made that it has been in the medical schools themselves that the cause of general practice has been harmed substantially. Several studies made in the United States have shown a steady and progressive decrease in the number of students intending to enter general practice as they progress through medical school. General practitioners claim that this is because the student has as models only his specialist teachers. There is the further fact that the clinical experience has been gained predominantly in hospitals, a setting in which the procedures and even range of health problems exhibited is quite unlike those of general practice. The undergraduate in most of his clinical experience has not been presented with an accurate picture of general practice. Dr. W. E. H. Alport, president of the College of Family Physicians of Canada, has stated, "Now the young doctor is superbly trained to treat the rare case he'll probably never see in day-to-day family practice".[25] Training in psychiatry, to help him deal with the numerous "functional" illnesses, psychosomatic complaints and minor mental disorders which he will see in practice has been quite limited. In general, as Grove reports:

> Until very recently at least, the medical schools have had two possibly contradictory goals: to lay the groundwork for specialist vocational training leading to a career in one of the recognized specialties, *and* to turn out doctors who, after a year or more of postgraduate rotating (or sometimes, "mixed" internship), will be fitted for general practice.[26]

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[24]*The Graduate Education of Physicians, op. cit.*, pp. 37-38.

[25]Quoted in *The Canadian Doctor*, June 1967, p. 10. Supported by evidence from Alumni Association of University of Toronto.

[26]J. W. Grove, *op. cit.*, p. 220.

Two recent American studies also have commented on the specialist bias of undergraduate education. The Ad Hoc Committee on Family Practice, reported to the American Medical Association Council on Medical Education that

> There is little formal instruction in the philosophy of family practice, and even more important, no example of a satisfactory model of family practice to provide experience in continuity of relationship with and responsibility for the patient. This is a crucial deficiency because students have no opportunity to observe family practice and to develop an interest in it. This experience would be valuable for all medical students, whether or not they eventually enter family practice.[27]

The Ad Hoc Committee further criticized the deficiency in preventive medicine, public health, and social and behavioural sciences, and the overemphasis on hospitalized patients in the undergraduate curriculum, calling for a greater flexibility in training programs. The Citizens' Commission on Graduate Medical Education reported to the American Medical Association that

> Educational opportunities that would serve to interest students in family practice and provide internes and residents with appropriate training are few in number and often poorer in quality than the programs leading to the specialties.[28]
>
> At present, medical schools provide excellent models of the scientist-research scholar and the hospital-based specialist, but rarely if ever do they provide models of comprehensive health care or of physicians who are highly successful and highly regarded for providing that kind of service.[29]

Such a situation detracts in two ways from the cause of general practice. In the first place, students are unlikely to be attracted to general practice; in the second, those who do opt for this field are less likely to remain than if they had been differently prepared.

We do not elaborate on the view of medical educators in Ontario, at this point, since we discuss relevant programs in the medical schools (which reflect their concern about it) at some length later in the chapter. Those in the medical schools are quite aware of the problem and are taking steps to deal with it.

The Role of the Generalist

Such, then, appear to be the disabilities under which general practice is carried on. The status of the general physician, within medicine, must be improved if recruitment into this area of practice is to increase. And the improvements must be of a number of kinds. But if they are to be effective it is essential that the role of the

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[27] *Meeting the Challenge of Family Practice,* The Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education, American Medical Association, p. 19. The Committee comprised representatives of the AMA Council on Medical Education, the American Academy of General Practice, the AMA Section on General Practice, and the Association of American Medical Colleges.

[28] *The Graduate Education of Physicians, op. cit.,* p. 38.

[29] *Ibid.,* p. 42.

general physician be as clearly determined as possible, in the changing state of medicine and medical practice. It will not do merely to try to revive the traditional general practitioner. The need is for someone with the skills in playing a role that suits him for the practice of medicine in a profession that is characterized by expanding knowledge and much specialization, that is carried on increasingly in settings such as hospitals and group practice, and that is associated with expanding numbers of non-medical personnel in a growing number of different health professions and occupations.

> The proper question would seem to be not whether we are to have general practitioners, but what is to be the nature of general practice.[30]

If it is accepted that there is an important role for a generalist, not as an isolated practitioner aspiring to encompass an impossibly broad range of medical skills within his competence, but as an integral part of an organized health delivery system, what kind of a physician should he be and what should his role be? There are differing views on these matters. These differences of view about the qualities of such a physician are reflected in the number of terms which have been coined to describe him, such as "family physician" (College of Family Physicians of Canada, American Medical Association Council on Medical Education), "primary physician" (Citizens' Commission on Graduate Medical Education), "personal physician" (National Commission on Community Health Services). Behind all these phrases lies a view of the general physician engaging in a distinctive form of practice that might be characterized as a special field of practice itself. There is considerable agreement about the components of this field. The basic function of this practitioner would be, first, to provide the patient's initial (and continuing) point of contact with the health care system and to make at least the important initial diagnosis in cases of illness; second, to provide a substantial range of curative and preventive service, and to refer to specialists when specialist services are required; third, to provide continuity in, and coordination of, health care for the individual; and fourth, to deal with many of the psychological and sociological aspects of health care.

First Contact Care

The basis for separating this function for special mention is the belief that neither self-referral to specialists nor initial screening by non-medical personnel provides a satisfactory means of entry to the health care system. It is believed that some kind of medical generalist most appropriately may perform the function. The "knowledge explosion" in medicine has enormously expanded the range of medical and health services available to the public. The agencies for their provision, however, are as yet not well coordinated and the potential consumer of services faces a discouragingly complex health industry. Even given his increasing sophistication

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[30]Murray Hunter and J. H. Sloss, "Problems of Participation of Family Physicians in a Medical Group Practice", *Medical Care in Transition,* Vol. 1, U.S. Department of Health, Education, and Welfare, Washington, D.C., 1964, p. 419.

in health matters, he cannot be expected to refer himself to the appropriate agency or health professional. He needs an adviser who, in the words of the College of Family Physicians of Canada can act as a "portal" to the health system and as the patient's "guide" within it. We find persuasive the contention that such an adviser must be a medical generalist, who can make a diagnosis for treatment or referral. Since he cannot predetermine the kind of disease for which the patient may consult him, the generalist must possess an overview of the various fields of medical knowledge in order, if necessary, to refer the patient to the appropriate source for further diagnosis and treatment. Furthermore, not only may the patient have *any* disease, he may have *no* disease.[31]

Hence the first contact generalist is charged with making one of the most important determinations in medicine, the initial diagnosis.

Recommendation:

348 That medical personnel should provide the initial contact between the patient and the health care system, and that steps should be taken to ensure that there are an adequate number of such initial contact physicians available to provide this service.

Treatment Services

After this initial determination, the generalist will often provide or arrange for complete treatment for many of his patients.[32] His training will prepare him to treat a large number of ailments, including minor "functional" disorders involving a considerable psychological component. Furthermore, given his initial contact and continuing association with his patient, the generalist is the most appropriate agent to provide the preventive medicine which must assume increasing importance in the scheme of health care services in the province.

Comprehensive Patient Care: Continuity and Coordination

As a personal or family physician, not only will the generalist perform first contact and referral functions within the health care system, but he will be equipped to coordinate the many forms of health care received by the patient and will assume responsibility for his continuing care. This aspect of his role has been delineated

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[31]John Scott, "The Work of the Physician in the Community" in *The Preparation of the Physician for General Practice,* World Health Organization Public Paper No. 20, Geneva, 1963, p. 16.

[32]The Hall Commission estimated that general practitioners provided 85 per cent of the personal medical care in Canada. A Saskatchewan study in 1966 (reported in J. W. Bean, "Future Manpower Needs in General Practice" *Medical Care Insurance and Medical Manpower,* Canadian Medical Association Conference, Montreal, June 19-23, 1967, pp. 127-33) found that general practitioners in Saskatchewan provided 87 per cent of all office visits, 94 per cent of home and emergency visits, 42 per cent of insured psychiatric service, 77 per cent of obstetrical care and 50 per cent of major surgery. These figures, however, must be interpreted in the light of Saskatchewan's ratio of two general practitioners to one specialist.

and emphasized by the National Advisory Commission on Community Health Services in the United States:

> Every individual should have a personal physician who is the central point for integration and continuity of all medical and medically related services to the patient. Such a physician will emphasize the practice of preventive medicine, both through his own efforts and in partnership with the health and social resources of the community.
>
> He will be aware of the many and varied social, emotional and environmental factors which influence the health of the patient and the patient's family. His concern will be for the patient as a whole and his relationship with the patient must be a continuing one. In order to carry out his co-ordinating role, it is essential that all pertinent health information be channelled through him regardless of what institution, agency or individual renders the service . . . He will have knowledge of all the health resources of the community — social, preventive, diagnostic, therapeutic, and rehabilitative and will mobilize them for the patient.[33]

The Psychological and Sociological Aspects of Patient Care

The little documented but widely accepted proposition that many of the cases which are dealt with by the general practitioner are psychological or psychosomatic in character leads to an argument for a physician with a personal knowledge of the patient in the context of his "micro-environment", the complex of roles which he plays in the context of family, community and work.[34] It was this emphasis on the psychological and social aspects of medical practice that gave rise to the replacement of the term "general practice" by the term "family medicine". The medical school at McMaster University, one of the Canadian pioneers in developing a program of medical education in family practice, hence defines the field as "a non-technical specialty centered about the family and the medical problems of the family. Its body of knowledge consists of medicine, paediatrics, psychiatry, obstetrics, minor surgery and trauma".[35]

The General Physician and the Specialist

We return very briefly to the question, mentioned at the outset of this chapter, of whether these functions might not be served by some means other than a general physician. Recognition of the declining numbers of general practitioners has led in the United States to attempts to replace the general physician with specialists, either individually or organized in an institutional setting, in complementary fashion, as "composite personal physicians".

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[33] *Meeting the Challenge of Family Practice, op. cit.*, p. 12.

[34] For a further discussion of the role of the generalist in mental health care, see Chapters 13 and 28.

[35] R. G. McAuley, "Family Practice: A Proposed Solution to the Problem of Meeting the Medical Needs of the Community", *Canadian Medical Association Journal*, Vol. 96, No. 14, April 8, 1967.

There are differences of view on these matters and the literature is vast. It is not possible for us to present all the arguments that have been made one way or the other and then to attempt to come to a conclusion that will convince everyone. In the first place, it is not clear what patients prefer because, aside from a small number of surveys and some statements of opinion based on general observation, surprisingly little systematic information about patient attitudes is available[36] and patient attitudes should count for something. Second, there is relatively little systematic information, based on well-designed studies, about the effectiveness of alternative methods of carrying out the functions we have just described, from the viewpoint of the overall quality of the preventive and treatment care provided.[37] Nevertheless, the literature and the information given us in our hearings reflect a great deal of thought, based on general observation and discussion and also on systematic exchanges of views, which has been given to this matter by members of the medical profession and by others.

In these circumstances we merely present our conclusions without attempting to argue fully both sides of the matter.

As we have said, we find persuasive what appears to us to be the preponderance of considered opinion that there is an important role for the generalist in performing the functions we have described although not necessarily to the exclusion of other types of arrangements as well. We believe that reliance upon individual specialists, *qua* specialist, to provide most or all comprehensive health care has undesirable consequences. The Millis report has this to say:

> What is wanted is comprehensive and continuing health care, including not only the diagnosis and treatment of illness but also its prevention and the supportive and rehabilitation care that helps a person to maintain or return to as high a level of physical and mental health and well-being as he can attain. Neither the hospital nor any of the existing specialists is willing, equipped, or able to assume this comprehensive and continuing responsibility; and too few of the present general practitioners are qualified to do so. A different kind of physician is called for.[38]

Dr. Herbert Ratner has summarized another critique of this method of delivery:

> We do need specialists for special cases but it is a scandalous waste of manpower and foreboding to medical economics for specialists to handle the usual illnesses, most of which, frankly, are self-limiting or lend themselves

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[36]See footnote 2 of this Chapter for reference to three surveys of consumer opinion.

[37]Herbert O. Mathewson has reported one such study in "Two Experimental General Practices", *Archives of Environmental Health,* Vol. 14, June 1967, pp. 809-820. In it he reports comparatively on his observations of the Montefiore Medical Group in New York City and the General Practice Training unit in Edinburgh, Scotland. The former group is a multispecialty group using thirty board-certified internists and paediatricians as "general physicians" along with many other specialists. The General Practice Training Unit is more like the McMaster experiment described later in this chapter.

[38]*The Graduate Education of Physicians, op. cit.,* p. 36.

> to simple remedies . . . If a specialist doesn't see special cases, he's not going to remain a specialist since he will lack experience . . . .[39]

From still another point of view, the Royal Commission on Health Services in Canada rejected the notion that the general physician must be replaced by specialists in Canada.

> With the advancement of scientific knowledge, specialization in medicine will continue to grow, but it will not replace the general practitioner, nor would such a development be desirable, especially in Canada's social and geographic setting. Only in the larger urban centres will all the existing specialties be represented. It is true, on the other hand, that modern means of transportation and communication make specialists' services accessible even to patients at a considerable distance, which means that there is less need for the general practitioner to engage in areas of medicine for which he has not been specially trained.
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> The specialist has assumed some of the functions of the general practitioner: the obstetrician, normal deliveries; the paediatrician, care of children; the internist, uncomplicated medical cases, and so on. In part, this has been brought about by public demand. Nothwithstanding this trend there continues to be a need for the general practitioner to retain his role as the family physician. Only he seems to be in a position to treat the whole patient. While he may refer an increasing number of cases to a specialist, referral and consultation may well develop into a two-way flow as patients after acute stages of severe illness are returned to the general practitioner for continued care, the supervision of home care services or rehabilitation procedures. General practice also plays an important and growing role in such fields as health maintenance and mental illness and has a place in the context of group practice.
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> Thus the future role of the general practitioner is of increasing significance. He will provide both preventive and curative medical services to those under his care on a continuing basis. When complex conditions arise, he will seek advice from his specialist colleagues: "You might call this man a patient-oriented community-based physician".[40]

With regard to "composite personal physicians" — groups of medical specialists and paramedical personnel functioning as a team — there are doubts that the potentials of this arrangement can be realized without the services of a coordinating generalist; indeed in many cases in which this arrangement has been used, specialists such as internists, have in fact, been the generalists. At the same time, it has been argued persuasively that the ideal place for the general physician to perform his coordinating function is within the context of such a group in which he, as the patient's personal physician, is backed by medical and paramedical

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[39]Herbert Ratner, "Deficiencies in Present Day Medical Education", *General Practitioner,* July 1965, p. 187. Quoted in Elton Rayak, *Professional Power and American Medicine,* World, Cleveland, 1967, p. 238.

[40]*Report of the Royal Commission on Health Services,* Vol. II, Queen's Printer, Ottawa, 1965, p. 242.

specialists. We are in agreement with the conclusion of Dr. L. T. Coggeshall in his report to the Association of American Medical Colleges:

> It is clear that the trend toward specialization will continue and increase. It is equally clear that some means will have to be found for providing family physicians — physicians prepared to accept overall responsibility for their patient's care over an extended period of time.[41]
>
> There is no clear alternative to the organization of modern medicine as a team effort — and the doctor must be trained specifically to function as a leader of the team.[42]

This view is reflected in our discussion of new patterns of general practice.

It has been suggested that the role of generalist can be performed by those existing specialists whose practices comprise a broad range of treatment: internists, paediatricians, and perhaps obstetricians and gynaecologists. Undoubtedly many such specialists, as well as existing general practitioners, will continue to perform this role. It may be that eventually there will be sufficient numbers of some kind of "new generalist" — specialists in personal or family care — to perform most of this work. While one cannot determine with certainty the extent to which this will prove feasible, it would seem desirable to utilize specialists to provide those services they are specially qualified to perform. Not only may specialists fail to make the best use of their special training if they engage in general practice, but there is a danger that by so doing they may lose some of the highly specialized ability that one may expect from a specialist. Ideally, we might look forward to the development of a specially educated medical generalist as the eventual solution to this problem, although we realize that this solution will not become available overnight.

Means of Improving the Place in Health Care of the General Physician

Returning now to the basic functions of a generalist, we are aware that they will receive different emphasis according to the context in which they are performed. For example, the role of the generalist will differ considerably in urban and rural milieux. The difference is well summarized in the following excerpt from an American study:

> The general practitioner continues to provide the vast majority of medical care in rural or semi-rural areas and will do so for some time to come. The organization of general practice is the key to any program designed to improve the quality of medical care for this segment of our population. The thesis that the general practitioner has no proper future in American medicine seems to us to ignore the real needs of a large number of Americans as well as to over-estimate the ability of our teaching institutions to turn out specialists in wholesale numbers. The proper question would

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[41] L. T. Coggeshall, *op. cit.*, p. 21.

[42] *Ibid.*, p. 25.

> seem to be not whether we are to have general practitioners but what is to be the nature of general practice . . . . Many metropolitan specialty groups are staffed by a multitude of part-time specialists and are often housed in large and somewhat imposing edifices.
>
> In such situations there is a need for the general practitioner "manager" or family counsellor to integrate, explain, and humanize the diagnostic findings. In semi-rural groups such as the one described in this paper the relatively smaller size of the group as well as the full-time status of its specialists permits them — as well as the general practitioners — to assume the role of "manager", depending more upon the nature of the problem than anything else. Here the general practitioner's role is more uniquely to provide a link between a relatively isolated community and a specialty centre.[43]

Faced with the emergence of an increasingly complex province-wide, but fragmented and potentially impersonal health delivery system, we are convinced that a medical generalist is essential to the satisfactory provision of medical services in Ontario.

The steps we think should be taken are those that will remove, where legitimate, those causes which have led to the numbers of generalist physicians declining more than seems appropriate to the developing patterns of medical care. This means that action will be needed on four fronts. First, there must be a change in the educational experience, so that those going into a general type of work will see other than hospital-based medicine. Second, something must be done to improve the professional status of the generalist. Third, his remuneration will have to be adjusted appropriately. And fourth, it will be necessary to improve his conditions of work.

We have not attempted, yet, to describe, in any detail, the kind of training that the new generalist might have. That will emerge in the following section.

Education of the Personal or Family Physician

> The general practitioner, in fact, represent(s) an educational challenge rather than a generally accepted and clearly visualized element in total medical care.[44]

It is clear that the traditional training of the general practitioner no longer equips him adequately for modern practice. Throughout both his undergraduate and internship training as it has been, with the possible exception of brief periods in the outpatient department of a large hospital, he is presented with hospitalized patients usually in a more or less acute stage of disease. But if the general practitioner is to function as a first contact generalist, a coordinator, and a personal physician, he must be trained as such, seeing patients who are representative of the continuum of health and disease which he will encounter in his practice, and learning to appreciate and utilize the skills of other health personnel. He must, in

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[43]Murray Hunter and J. H. Sloss, *op. cit.*, pp. 419-420.

[44]*The Preparation of the Physician for General Practice, op. cit.*, p. 22.

other words, be presented with a model of general practice which is relevant to the health care system in which he will practise. Some attempts to provide such models of practice have been made through preceptorship programs in the offices of community physicians. Such programs, however, are only as good or bad as the preceptors, and too often their function has been to perpetuate an increasingly outmoded concept of general practice and/or to discourage recruitment by presenting students with evidence of the overwork and frustrations involved in traditional general practice.

In order both to train and to recruit general physicians it is essential that general practice enjoy departmental status and facilities within the medical school and the teaching hospitals similar to those enjoyed by other clinical specialties. General physicians should have full staff appointments to both academic and clinical departments of family practice. Moreover, the university must take an imaginative lead in developing new models of general or family practice.

Throughout this Report, the Committee has refrained from making detailed suggestions upon the particular course content of professional curricula. As laymen, we must observe similar restraints concerning the education of the new medical generalist. Nonetheless, two general comments may be appropriate here.

First, the clinical education of the student physician need not take place mainly or exclusively in the hospital. Community health clinics associated with medical schools, where they are brought into existence, may afford the student desirable experience in dealing with a larger cross-section of ambulatory patients and the common minor ailments of a general population. Such experience will be invaluable to him when he enters general family practice, and is not always readily available in the hospital teaching setting. The more experience students receive in community medicine, the better.

Second, there appear to be real advantages in experimenting with a revised undergraduate medical curriculum, as McMaster University is doing, so that a more appropriate set of skills may be imparted to the student, a set of skills more likely to be useful to the physician when he enters family practice. It is desirable, for example, that the curriculum place appropriate emphasis on internal medicine, paediatrics, psychiatry, preventive health procedures with perhaps obstetrics and minor surgery. To make specific and detailed recommendations on particular courses would be beyond our competence, but we believe that the education of all physicians could include appropriate courses and experience in comprehensive health care and community medicine in the broadest sense. Here, however, we speak particularly of the general physician. Moreover, we regard it as important that the student physician work with and be made aware of the roles of other healing professions and groups such as nurses, psychologists, optometrists, chiropodists and physiotherapists. Nor should the contributions to the health system of the social and behavioural scientists be ignored. In short, the education of the general physician should be more comprehensive, and increasingly oriented to preventive and community medicine.

There has been encouraging evidence in recent years that Ontario medical schools have recognized the need for changes in the training of general practitioners, at both undergraduate and graduate levels. Some beginning on change has been made. Family practice units have been established in teaching hospitals affiliated with McMaster, Toronto, Western, and Queen's medical schools, but only at McMaster and Western, and as of September 1969 at Toronto, have they been operated under the aegis of an academic department of family medicine. The other units have been operated as part of organized outpatients departments or clinical departments of general medicine. Again with the exception of the McMaster and Western units, which consists of four full-time general practitioners and a supporting health team, these units have been staffed with a few full-time personnel.

McMaster, enjoying the advantage of a blank slate upon which to map a medical school, has undertaken, as indicated, the most thoroughgoing revision of the traditional mode of education for general practice. It has given both academic status and clinical responsibilities to general practitioners, and plans, through its family practice unit, to educate them specifically for the new type of family medicine, presenting them with a representative sample of patients drawn from the community, and associating them throughout their training with other health professionals. Until now, only postgraduate medical students have enjoyed the advantages of this educational structure; McMaster admitted its first undergraduate students in September of 1969.

This year also marks a change in the undergraduate program at the University of Toronto. A new academic department of family and community medicine has been established to provide medical students with "a greater exposure to general practice and closer association with family doctors in their natural environment.[45] It will assume responsibility for the direction of the education programs in the family practice unit mentioned above. The major locus of family practice education will be the university-owned Sunnybrook Hospital. Currently five full-time and fifteen part-time general practitioners staff the medical outpatient clinic operated by the Department of General Practice. Under the new Department of Family Medicine this family practice program will be strengthened. Plans are under way for a hospital-based practice of three teams of general practitioners responsible for three geographically defined areas. More tentative plans envisage the extension of educational programs to satellite medical practices based in the community. Both the McMaster and the Toronto programs involve a considerable research component, including clinical research into medical problems of family practice, educational research into methods of training family physicians, and research into patterns of delivering health care.

Training for family practice at the graduate level is now carried out by two teaching hospitals in the province: Henderson General Hospital in Hamilton and St. Joseph's Hospital in London. The focus of each program is a family practice

[45]University statement reported in the Toronto *Globe and Mail*, May 27, 1969.

unit, although in accordance with the requirement of the Ontario College of Physicians and Surgeons that candidates for licensure complete an approved junior rotating internship, the program also has involved rotations around hospital wards. These programs, leading to certification in family practice by the College of Family Physicians of Canada, are currently of three years' duration, but recent policy changes by the College of Physicians and Surgeons of Ontario suggest that they may be shortened by one year.[46] Recognizing the common trend in Ontario medical schools towards making the fourth year a clinical clerkship, the College of Physicians and Surgeons now allows graduates of such programs to take straight internships — internships that mark the beginning of specialization — rather than rotating internships. Consideration of a year in a family practice program as a straight internship would obviate the necessity for postgraduate students in family practice to rotate around hospital wards in the equivalent of a rotating internship year, thus eliminating this year from the program. The first graduates of these postgraduate programs were certified in June 1969.

The Committee believes that programs such as these are essential not only for the recruitment of badly needed general practitioners, but for training them to function within the context of modern medicine.

Recommendation:

349 That the Government of Ontario promote the adoption and extension of educational programs that make personal or family practice a separate (specialist) category in the undergraduate program and provide recognized postgraduate specialty training in this field.*

One further important matter in this area of education for general practice is that of continuing education. Continuing education is essential for the re-education of general practitioners now in practice so as to acquaint them with new clinical procedures and new patterns of practice, as well as for maintaining the level of skills of current graduates in family practice. Proposals concerning continuing education of physicians have been made in Chapter 8. It is evident from the difficulties encountered by the College of Family Physicians of Canada, which has made participation in continuing education programs a compulsory membership requirement, that the provision of such educational programs themselves is not enough. What is required are organizational arrangements which will encourage informal, "on-the-job" education and which will allow the physician enough freedom from clinical duties to engage in formal programs of continuing education. Various forms of group practice, both in lessening professional isolation and in

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[46]See Chapter 8, for the general changes in the undergraduate program now taking place in Ontario's medical faculties. The College of Physicians and Surgeons has encouraged these developments. See College of Physicians and Surgeons of Ontario, Transcript of the Hearings of the Committee on the Healing Arts, July 5, 1967, pp. 5691 ff.

*See minority opinion, pp. 228-230.

allowing a more predictable rationing of time away from practice, offer a promising solution. The association of the general practitioner with his medical colleagues and other health personnel in the hospitals is, as we have argued before and shall argue again below, an integral part of any program of continuing education in the broadest sense.

Professional Status

We are convinced, however, that educational programs, while necessary, are far from sufficient to ensure an adequate supply of general practitioners. The status and working conditions of such personnel must also be improved, and this may require changes in the regulatory structure.

> The first necessity is for organized medicine to recognize — not merely in a formal sense, but sincerely — that comprehensive health care is a high calling, different from specialization in thoracic surgery or hematology or something else, but not inferior — not inferior in training, in rewards, or in position within the house of medicine.[47]

The changes in professional status that are needed if general practice is to become a more attractive and rewarding field of medicine are of two types: those involving the improvement of the general status of the general physician, and those involving an improvement of his hospital privileges.

Professional Recognition

The College of Family Physicians of Canada, established in 1954 as the College of General Practice of Canada, in addition to fostering the educational programs discussed above, has done much to promote changes of both these kinds. It has established a formal certification in family practice, which, as of June 1969, it began to award to general physicians successful in passing a qualifying examination; most candidates at such examinations will be those who have taken postgraduate training in the family practice residency programs described above. In April 1968, the Royal College of Physicians and Surgeons formally "recognized" the College of Family Physicians of Canada as the certifying body for family practice.

The recent achievements and innovations of the College of Family Physicians and the role that it can play in the future in education for family practice — undergraduate, postgraduate, and continuing — are substantial. However, if family practice is to be made as attractive a field of practice as are the traditional specialties, it is most desirable that it be made even more comparable in status and remuneration to these specialties. It will be difficult to achieve this end as long as certification by a separate body implies, or appears to imply, any degree of inferiority of status for family medicine. It would be most helpful, in our judgment, if the Royal College could see its way to becoming the body that grants

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[47] *The Graduate Education of Physicians, op. cit.*, p. 28.

certification in personal or family practice. Such a step would help make the certified general physician an equal with his other specialist colleagues.

It is understandable that formal recognition of family practice as a specialty by the Royal College has not yet been forthcoming, because it has been the traditional procedure of that College to accord official recognition of new specialties only after such groups have clearly emerged and become established. On occasion, new specialties have arisen as divisions of existing specialties. In such cases, the practitioners concerned may have continued to obtain recognition as a specialist, even though it may not have been in the new category that ultimately emerged. A specialty in family practice does not appear to be one that would emerge readily in this way. We hope that this situation will not delay unduly the recognition of family practice if such can be done. We note the recognition of this specialty in other jurisdictions. In February of 1969 the Council on Medical Education of the American Medical Association and the Advisory Board for Medical Specialties announced the establishment of a new Specialty of Family Medicine. We hope that a similar step might be taken in Canada by the Royal College of Physicians and Surgeons at an early date.

In any event, we believe it important that the College of Physicians and Surgeons of Ontario, the official specialty recognizing body in Ontario, accord recognition and certification to the new specialists in family practice. We believe it would be constructive if the Ontario College also took the initiative in raising the matter of recognition with the Royal College itself.

Recommendation:

350 That the College of Physicians and Surgeons of Ontario take appropriate action to recognize formally the new specialty of personal or family practice.

Hospital Privileges

A second means of raising the professional status of the general physician lies in the improvement of his hospital privileges. We have commented on the adverse consequences for the general physician of exclusion from, or limited access to hospitals. Moreover, we have noted the importance of access to a hospital in the maintenance of continuing competence in the profession, and following from that the maintenance of quality of practice. We realize that many things must be taken into account in the granting of hospital privileges; among these the hospital's contribution to the maintenance and improvement of the quality of practice in the community is not unimportant. If the situation as it exists now is to be improved, the hospitals of Ontario, and in particular the teaching hospitals, must modify their procedures with respect to acceptance of specialist credentials in family practice to ensure effective recognition and utilization of the specialist skills of the new family physicians. We would go further and recommend that all general

physicians have at least some association with a hospital so that they may benefit from the exchange of knowledge in it.

Recommendation:

351 That qualifications in the specialty of personal or family practice be recognized in the regulations of hospital medical advisory committees as warranting status and privileges comparable to those enjoyed by other specialists, and that, if at all possible, some hospital association be available to all practitioners.*

Remuneration

We have noted already the increasing importance, especially with the advent of OHSIP, of the professional fee schedule in the determination of the remuneration of physicians. We have also noted how this schedule affects the general practitioners. If physicians are to be attracted to enter and remain in this field, it must be made more remunerative relative to specialty practice than is the case at present. In particular, specialty qualifications in family medicine should be recognized in fee schedules as warranting remuneration comparable to that in other specialties. We know that there is a relationship between the remuneration of an occupation and the length of time spent in preparing for it. But length of training is not the only matter determining remuneration of any occupation or profession. Further the prices set in fee schedules are administered and not market-determined prices. There is no reason why one of the factors affecting the determination of fees should not be the need to make a particular mode of practice attractive.

Recommendation:

352 That the Government of Ontario take the initiative in negotiating changes in the fee schedule which will provide financial inducements to prospective entrants to personal and family practice, and make the practice of personal and family medicine, especially as a specialty, more remunerative and attractive than it now is.*

New Patterns of General Practice

The changes that we have suggested already will not, by themselves, remove the disabilities of general practice associated with long hours of work, being on call for long and irregular hours, and being subject to requests for care that seem unreasonable. These things can be alleviated, for those who on balancing all factors want to change them, only by the development of forms of practice and arrangements among physicians that enables the physician to know that his patients will be taken care of at all times and at the same time permitting him more "free"

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*See minority opinion, pp. 228-230.

time than he has now. In very considerable measure, such changes in form of practice depend upon physicians themselves.

Such changes have been taking place. As noted in Chapter 29, there has been a very considerable increase in group practice in Ontario over the last few years. There appears to be also a growth in less formal arrangements, including a number of physicians just covering for one another. We believe that the future of organization of practice lies in the direction of combined practice and we have devoted some attention to this matter in Chapter 29. Indeed, it will be seen from the earlier parts of this chapter that many people, both in medicine and outside, believe that the best setting for the practice of the well-trained general physician is in some kind of group. But we have given already a more extended discussion of this matter in Chapter 29.

Recommendation:

353 That the Government of Ontario take such steps as are available to it to promote an improvement in working conditions for generalists. Suggestions for such measures would include tangible action to promote group, clinical and other forms of combined practice, to facilitate the association with, and, to the greatest degree practicable and desirable, use of health facilities, to help with experimental forms of health services delivery.

A Nurse Assistant

These changes in the position of the general physician and in the organization of ways of delivering health care may be facilitated by and at the same time require the development of new types of health personnel as well as the development of new interrelationships among existing health personnel. In particular, if the general physician is trained in the manner we have described, there will be a very large gap in education and training between the physician and the next level of health care personnel.

The availability of someone with a higher level of training than the general nurse, to assume, under medical direction, some of the more routine tasks now performed by the physician, could relieve the physician of many activities which now constitute an inefficient utilization of his skills. Although detailed studies of clinical activities of general practitioners are lacking in Canada, a strong impression is gained from the statements of physicians such as those made by Clute that much of the general practitioner's time is needlessly expended in the performance of clerical and minor technical functions which could be delegated to ancillary personnel.[48] Experiments in the development of a new kind of health worker — the physician's assistant — at Duke University in North Carolina illustrates one attempt

[48]K. F. Clute, *op. cit.*, pp. 56-81, esp. pp. 79-81.

to develop new ancillary skills. This type of personnel is being trained in a two-year program to perform technical functions under the supervision of a licensed medical practitioner. Graduates of this program will be employed in research and public health work as well as in private practice, but it is their potential contribution in the latter context with which we are concerned here.

Possibly even more promising, given our existing conditions, is another type of response to the need for ancillary personnel, the attempt to utilize nurses with various types of specialty training as physicians' assistants. Such a person appears to have the greatest potential in various forms of combined practice where her own skills could be most fully utilized.

Several pilot programs in Canada have investigated the possibility of attaching nurses to a general practice as case workers to monitor the health of patients both at home and in the office, to provide counselling, and to utilize community resources in the interest of the patient. Although the functions performed by the nurses in these pilot programs are unlike those which we have in mind, it is perhaps worth noting briefly some of their features. The nurse in these pilot projects has only minor medical functions and does not diagnose or initiate treatment, and her contribution is chiefly in assuming the non-medical sociological and routine technical functions of family medicine.

In January 1967, the Public Health Unit of the Toronto borough of East York, in conjunction with four East York general practitioners and the University of Toronto School of Nursing, established a Special Public Health Nursing Project, in which a public health nurse is seconded to general practitioners (not engaged in group practice), making home visits to their patients and holding weekly conferences with each physician to discuss the patients' progress and problems. Such an arrangement is held to be a considerable improvement over typical public health nurse-family physician relations. One study of previous relationships between three public health units and three G.P.'s whose practices coincided roughly with their respective jurisdictions in London, Ontario, indicated that although a majority of the families visited by the nurse had a "family physician", only rarely did the nurse contact the family physician, or recommend that he be contacted. Patient-nurse contact was similarly rarely initiated by the physician.[49] The East York arrangement appears to have been a distinct improvement.

A more ambitious program, now being attempted in Saskatchewan, involves the use of a nurse as a "clinical case worker" in the Prince Albert Community Clinic, a seven-physician group practice, including general practitioners. Here a graduate nurse, with postgraduate training in public health and psychiatric nursing, acts, in her words, as a "correlating centre for the total care of the patient". Her functions are less extensive than this would suggest, however; in fact she correlates the non-medical with the medical aspects of the patient's care but has little discretion

[49]Dennis Brannon, "The Public Health Nurse and the Family Physician", *Journal of the College of General Practice of Canada,* June 1966.

concerning the latter.[50] We believe it worth trying the development of a nurse, with postgraduate training, to provide more direct assistance to a physician, or a group of physicians in office or group practice. She would not be a person who screened patients before they saw a physician but she could relieve him of many tasks which he now does, but which she would be qualified to perform.

A few examples may help to clarify and emphasize the point. There are many important but relatively routine tasks, now performed by physicians in private offices, which might well be performed instead by auxiliaries. Much medical time is taken up by such matters as simple prenatal consultations with mothers, well-baby care, taking of case histories and keeping of case records, filing and billing, consulting with patients on matters of diet or family planning, taking blood or other samples for analysis, and the like. Many of these functions might well be performed by the physician's assistant under his direction and with appropriate direct contact between the physician and patient as occasion warranted.

The physician's valuable knowledge then would be devoted to performing those functions which only he can perform. An argument is made that when the physician is relieved of marginal tasks, he will perform his specifically medical functions better and utilize his diagnostic, curative, and preventive health skills more fully and more efficiently. He might be able either to spend more time with individual patients, or to see larger number of patients. In either case, the quality of his practice is likely to improve as he becomes more free to devote his time to the things he is trained to do and does best.

The Committee sees such a medical assistant as we propose here as being, perhaps, a nurse with special postgraduate training that would equip her to carry out more complex functions than the ordinary nurse does now. We believe that her contribution would be particularly effective in combined practices and especially in group practice and community practice settings.

We do not make recommendations about the length of postgraduate training or its form. These matters must be determined by those knowledgeable in the field. There is experience to be drawn on from the part played by nurses in some hospital arrangements, in public health programs, and in the use of nurses who have received training on the job in some existing practices. We do believe, however, that a formal educational program to provide such training should be established, at least on a pilot project basis initially.

Recommendation:

354 That the development of a higher grade medical worker such as a nurse with postgraduate training, to assist the physician in many of the routine tasks now being performed by him be undertaken and that, at least on a pilot project basis, a formal training program for such workers be established.

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[50]J. M. Mossing, "Nursing Case Work", *Canadian Nurse*, June 1966.

Minority Opinions

Minority Opinion on Chapters 24, 25 and 26 on Questions of Administration and Planning, Regulation and Education

My colleagues and I are in substantial agreement on the inadequacies of the present health services structure as described in Chapters 4 and 5, and also about the nature and cause of the problems discussed in these chapters and the obvious need for a more effective integration of the components of the system for health care into a health services delivery system organized to a sufficient extent to be responsive to province-wide and interdisciplinary planning based on an objective analysis of the consumers' needs.

We have agreed that many of the problems have arisen because it was not clearly the responsibility of any particular body to attempt to foresee them and forestall them, or to coordinate the attack on these problems by the various components of the healing arts affected by each problem. We are agreed that such responsibilities must now be undertaken by an appropriate body and the majority, in recommendations set out in Chapter 24, recommend that this body be the Department of Health. I feel, for a number of reasons, that it would be better if these responsibilities were entrusted to a Commission to be established for this purpose to be known as the Ontario Health Services Commission. In the following pages I will explain why I do not believe that the Department of Health is the appropriate body, why a commission would be preferable, the composition and organization of such a commission, how it would function, its powers and its relationships with other bodies. I will then discuss the problems of regulation dealt with in Chapter 25, and Education in Chapter 26. I deal with these three chapters together because I believe that the establishment of the Health Services Commission will make a great contribution to the solution of the problems of regulation and education, making unnecessary, in my opinion, a number of measures which are recommended in these chapters.

Administration and Planning

In proposing that the Department of Health assume the new responsibilities outlined in Chapter 24, it is suggested in Recommendation 293 that the Department be relieved of direct administration of health programs as far as this may be feasible. Elsewhere it is suggested specifically that the Department would relinquish its responsibility for the Ontario Hospitals, and also for OHSIP, both of which would be taken over by new bodies to be established for this purpose.

The components of the health care system are professional and occupational groups of people and institutions, for the most part, as a result of licensing or similar provisions, enjoying a monopoly to perform their services. These are the

suppliers of health services and we have discussed in Volume 2 the merits of the services which they supply, and some of the circumstances which cause them in certain cases to be less than ideal. As is explained in Chapter 5, the ineffectiveness of "free market forces" to influence supply and demand for health care services, and the difficulty of the consumer in deciding just what service he needs has produced a system in which the suppliers really decide what services will be supplied. This is clearly undesirable if it can be avoided, and so it seems to me to be of paramount importance that a body created to organize a system for the better and more efficient delivery of health services should be consumer-oriented, advised by representatives of the healing arts, and not the reverse.

The Department of Health is a supplier. It was established some ninety years ago for the purpose of supplying health services, and it has grown in size and importance as it has undertaken the supplying of additional services. Because this has been its principal function it has a long history of executive direction by members of the health service supplying professions, principally physicians.

Although one may question whether this has not been overdone in the past, it is certainly not inappropriate, and it is probably essential to the proper fulfilment of many of its programs. All but four of the Ministers of Health who have administered the Department during these years have been physicians, and although the present Minister, appointed in 1969, is one of the exceptions, there is no indication that the appointment of a non-physician was a policy decision.

Even if the Department of Health were to be relieved of its functions relating to OHSIP and the Ontario Hospitals, it would still be responsible for a very large number of complex and widely varying activities as can be seen in Table 4.1 (Volume 1, Chapter 4), which lists the legislation which this Department administers. The day-to-day pressures of these important duties, which would include the supplying of many services, would limit the amount of attention that the Minister and his Department could give to health care delivery planning.

The latter is a virtually new function which must be given high priority and it is appropriate that it should be tackled intensively by an agency that has no other distracting responsibilities. The Gordon Committee on the Organization of Government in Ontario in 1959, discussing the rationale for boards and commissions, said "it may be desirable to create a separate board or other agency where the government is taking on a new function the limits or requirements of which cannot be fully defined or anticipated". This would seem to be just such a situation.

The members of the Ontario Health Services Commission and their senior staff, by concentrating their attention on policy analysis and the production of alternative strategies for health care delivery, would become experts in this field, concerned not with how to perform health care services but rather with how to plan and administer the delivery of such services. The need for the development of such expertise is similar to that which in a more limited field produced the hospital administrator to replace the doctors and senior nurses who were generally

appointed to such positions until it was found that other people were better qualified to deal with the complexity of modern hospital management problems.

The Department of Health appears to be well organized and well staffed for its functions, and to be performing them well, and I find it difficult to understand the wisdom of partially dismantling such a structure for the purpose of making it better qualified, although still far from ideally qualified, to assume some new responsibilities which could just as readily be given to some other body established for the purpose of undertaking them, and appropriately organized and staffed to do so.

It would seem to me to be preferable to let the Department of Health retain its supplier responsibilities and rather to rid it of such responsibilities as it has for the healing arts and for OHSIP. The Department can then remain organized and staffed as it is appropriately for its role of supplier. The Minister of Health may be a physician or not as the Prime Minister chooses, and more important he can continue to be surrounded by advisers and department heads drawn from the supplying professions; this would be inappropriate in a body which is to shape public policy in such critical areas as priority for the allocation of health resources to supply needed services and control sky-rocketing health care costs.

In Chapter 24 we make the recommendation that OHSIP and OHSC be brought together under a new board, the principal reason being the importance of avoiding inconsistencies in the policies of these two bodies. We have, throughout the Report, recommended some changes to correct anomalies which appear to encourage unnecessary hospitalization for the purpose of obtaining coverage for services which are presently covered only if they are performed in a hospital. It would seem that the best way to ensure that such problems do not arise in the future would be to bring both bodies under the same direction. I believe that it is imperative that this body, for which the title "Health Services Insurance Commission" is suggested, be responsible to the body undertaking the development of the health service delivery system for two reasons. First, it is absolutely imperative that the policies of the insuring bodies and the implementation of these policies be consistent with health services system planning, and second, the administration of the OHSIP and OHSC resources would be the most potent aid that the new body could have in enlisting the cooperation of health services practitioners and institutions.

This would mean that if the Department of Health were to have the responsibility for the development of the delivery system, the Ontario Hospital Services Commission would come under its direction, an option which was open to the government at the time OHSC was set up and which appears to be undesirable for several reasons, which may well have influenced the government decision at that time, and which are in fact very much the same as those I advance now for the preference of a Health Services Commission to the Department of Health.

As we have said, most of the institutions and individuals engaged in the healing arts enjoy a monopolistic position, conferred on them in the public interest, but nevertheless very advantageous economically to them. This means that the public is entitled and is coming to expect from them the same availability and adequacy of efficient service as it expects from a monopolistic public utility such as, for instance, hydro, broadcasting, transport and the telephone company. It is a common pattern in government that the responsibility for seeing that a monopolistic industry does maintain adequate standards of service is entrusted to a commission, and it seems to me that a similar intervention is essential in the highly fragmented private services sector of health services.

The basic problems which make the development of an organized system essential are the general shortage of supply of some services, the poor distribution of some services, and the rapidly rising cost of all health services. This last problem, already very serious, is likely to become even more so if the solution to the problem of dealing with shortages and maldistribution of services is to be the addition of more resources. Obviously this is to be avoided wherever possible and a primary objective of planning the system must be the development of greater productivity from existing resources. It is intended that a Health Services Commission would not itself supply any services but would simply be responsible for seeing that they were supplied by the present suppliers to the highest possible standards of quality and quantity which the available resources would permit. To do this with a minimum of organization and without regimentation is likely to require the development of incentives to individuals to enter undermanned services or to serve in underserved areas, and to both individuals and institutions to adopt methods of operation which will produce greater efficiency. It may be that a commission would have greater freedom to adopt such devices without creating precedents which could be embarrassing to a government if they were administered by a department. The urgency of the need for health care services is so irresistible that heroic measures can be justified. It may be difficult at times to persuade other departments and the consumers of their services that the urgency of their problems is not such as to justify the same measures.

The first step that the Health Services Commission would undertake would be the assessment and evaluation of the above problems, shortage, maldistribution and cost of services, district by district and in total, to consider to what extent they could be relieved by measures which developed greater productivity and to what extent additional resources were required.

The second step would be the establishment of priorities for the application of resources to required services and for the development of programs to make the delivery of services more efficient.

The third step would be the evolving, initiation and support of plans for the optimum application of additional resources and for the achievement of the accepted standards for quality, quantity, availability and efficiency of health services in the province.

In the performance of these functions the Commission would be advised by the Ontario Council of Health, which would be changed in some respects which I will discuss later and would become the advisory board to the Commission rather than to the Department of Health. Thus we would have these decisions which require a completely objective study of the consumer needs and the supplier potentials and which should be based entirely upon the public interest, being made, as we have suggested that they should be, by a consumer-oriented body advised by suppliers.

These decisions would become the basis of the provincial health care policies which would be established either by the Commission within guidelines laid down by the government or by the Cabinet acting on the recommendations of the Commission, depending on the powers which it was felt that the Commission should have. Clearly the effectiveness of the Commission would be limited if its role in policy-making were to be purely advisory. The degree to which programs based on the accepted policies had to be approved by the government would of course be a matter for the government to decide, but it would be hoped that once the government had approved the policies which were to govern the operation of the Commission, it would be given a fairly free hand and adequate powers to carry them out.

In addition it would have the responsibility of applying the criterion of public interest to the actions or proposed actions of all bodies engaged in health care services. For this purpose it would clearly need some disciplinary powers but what these should be would again be a matter for the government to decide.

The Commission should be created by statute and the act should state that the chairman, the executive head of the Commission, should be a layman in the sense of not being engaged in any health care profession or occupation, and should be responsible directly to the Prime Minister. The Commission should be a small body consisting of possibly no more than three laymen, or if it is thought desirable to add health care professionals, perhaps seven members, a majority of whom would always be laymen. The Commission would have to be on an equal footing with the Departments of Health, of Education, and of University Affairs, and the chairman should have equal status with the Ministers heading these departments.

The advisory council, the Ontario Council of Health, should also be established by statute and its functions should be spelled out in broad terms in the legislation. It could be very much the same size and composition as it is at present, consisting of both health care professionals and laymen with a preponderance of the former. It would be desirable to have more health care disciplines represented than there are in the present Council, even if this meant enlarging the Council; and the chairman should be a layman, possibly the chairman of the Health Services Commission or another member of that Commission. The Council would have a Research and Planning organization, and in addition to advising the Commission and directing research and experimentation on behalf of the Commission, it would be free to initiate studies on its own and to make recommendations to the Com-

mission. It is because of this relationship that it is suggested that membership of the Commission might be limited to three laymen.

The operation of the Commission would be through a regional and district structure, such as has recently been adopted for various health care activities, particularly public health, and has been outlined by the Committee on Regional Organization of Health Services appointed by the Ontario Council of Health. The immediate development of such a structure would be necessary for the collection of the data on health services and consumer needs on which the analysis of provincial, regional, and district problems will be based, and it would be most important that the districts and regions be logical units for the organizing of health services, and not be based on any other consideration, such as that suggested by the Ontario Council of Health, that regions be centred on the health sciences centres of the universities. This, it seems to me, would be quite wrong as it would tend to establish immediately a professional domination of the structure which is just as much to be avoided at the regional and district level as it is at the central policy-forming level. The teaching hospitals in these centres will, of course, continue to be each the apex of the pyramid of inter-hospital referral in its area. This is bound to influence thinking on regional border planning, but the administration of the regions should be centred on the regional offices of the Commission and should consist of a board of professional and non-professional people representing the districts in the region, chaired by the regional officer of the Commission, a full-time employee of the Commission, preferably experienced in health planning and administration. Moreover, it should be concerned simply with the health care needs of the region and measures to ensure that they are met effectively in terms of availability and accessibility of services, and efficiently in terms of utilization of skills and money.

District administration would consist of a district council of some ten members, representatives of health professions, local government voluntary organizations and consumers, with a chairman, a layman, appointed from their number. District offices and staff would have to be made available by the Commission if this proved necessary; but since neither regional nor district councils would be in the business of providing services, as are the public health units, but simply coordinating the efforts of individuals and organizations which are providing services, it would be hoped that district offices would not be necessary.

It is not the intention that the existing pluralistic approach to health care should be altered in any way, and the activities of the regional and district boards would be directed towards dealing with gaps in the services, and the initiation and coordination of programs which required interdisciplinary coordination or the cooperation of a number of individuals, organizations or institutions.

The district boards would provide the regional offices, and they in turn the central administration, with a picture of the health care services in their jurisdiction, which would enable the Commission to determine the prevalence of local problems

and the dimensions of provincial problems. At the same time, district and regional offices would submit plans to deal with the problems and indicate where financial or other support from the Commission would be required.

The Commission would then present to the government a picture based on these reports reflecting the unsupplied needs and recommending what the provincial policy should be, the order of priority in which problems should be dealt with, and the plans for their proper solution.

With the policies adopted and, if necessary, the plans approved, the Commission would then approve local plans or supply guidelines for the formulation of local plans, giving assurance of the financial or other support which would be forthcoming for the implementation of approved plans. Financial support would of course come from government appropriations administered by the Commission. These plans would be carried out by local institutions, organizations, or individuals.

There has been in recent years a growing awareness of the need for comprehensive health planning both in this country and in the United States where the federal government has offered grants to the states for the support of programs which would follow federal government guidelines in the establishment of comprehensive health planning at the state, regional and district levels. A condition for the obtaining of federal assistance is that a majority of the members of the State Advisory Council on Comprehensive Health Planning must be laymen, representatives of the consumers of health care services. This and a crash program in a number of major universities in the United States for the development of health care planners and administrators reflects the growing realization that just as war in Clemenceau's words became "too serious to be left to the generals", health care planning problems have become too complex and too serious to be left to the health care organizations which have neither the responsibility nor the authority to endeavour to develop an integrated health care system.

I should say at this point that in the course of our studies we came across many representatives of health care professions doing excellent jobs of administration and planning, often in conjunction with demanding professional duties, and we were greatly impressed with the administration of the Department of Health by Dr. Matthew Dymond, his Deputy, Dr. K. S. Charron, and his department heads with whom we had a number of meetings. What I believe must be guarded against in the health care planning area is the assumption that this must be run by the senior health care professions, because in this assignment administrative and planning skills are more essential than professional education and experience. Moreover we are discussing a new responsibility which involves the taking or recommending of decisions which might, for example, benefit physicians at the expense of other disciplines or dentists at the expense of the public; and so I suggest that there should be applied to this structure the generally accepted principle that important public decisions should not be taken or unduly influenced by people whose own interests may be involved and may be in conflict with the public interest.

Members of the Commission and members of the Ontario Council of Health would be appointed by the Lieutenant Governor in Council, officers of the Commission and the chairmen and members of regional and district boards would be appointed by the Commission, the chairmen and members for appropriate periods of tenure.

In addition to its responsibilities for the adequacy of health services, I believe that the Health Services Commission should be made responsible also for the surveillance of the operation of the regulatory bodies established to regulate the affairs of professional and occupational groups, to ensure that the activities of these organizations are consistent with the public interest. This would enable the Commission to satisfy itself that educational requirements and other specifications for admission to the professions or occupations were not excessive, thus increasing the cost of the education or training and tending to inhibit the recruitment of needed personnel.

Regulation

The supply of educated and trained people for the health services system is so vital to its ability to meet the consumer requirements that obviously the Health Services Commission must have a very lively interest, not only in the educational and training institutions and the authorities who determine who shall be admitted to them and what they shall be taught, but also in the regulatory bodies who determine the qualifications for admission to the professions and occupations.

Like my colleagues, I am opposed to the creation of a monolithic system with a professional education and licensing division of a central authority taking such decisions based on manpower needs and health care priorities, and I agree with them that it would be a great mistake to interfere unduly with self-governmental powers being wisely exercised in the public interest, or to ignore or minimize the importance of pride in a profession.

Obviously, however, there must be communications through which the needs of the health care system exert influence on the deliberations and decisions of regulatory and educational bodies, and it is with such interrelationships that Chapters 25 and 26 are largely concerned. Again I am in agreement with the statement of the problems in these two chapters but in sharp disagreement with some of the proposals made for their solution.

I agree that there has been a tendency on the part of bodies empowered to regulate professional or occupational groups to forget that their powers were delegated to them to be used in the public interest and that their occasional misuse of these powers is reflected by some regulations and by-laws which are concerned with the interests of the group and neglectful of the public interest.

I agree also that the approval of such regulations, the acceptance of the enactment of such by-laws and the passage of carelessly worded legislation are all attributable to the "absence of a public repository of responsibility".

Agreed, also, are the needs for reform, for the reviewing of all the legislation and rewriting of much of it, and for the delegation to an appropriate body of the responsibility to keep a watchful eye on "future legislation and the behaviour of the professions".

Here we part company because, as I have indicated above, I believe that the appropriate body to undertake this responsibility is the Ontario Health Services Commission, the body which I have proposed should be established to coordinate the planning and organization of the health services delivery system and to ensure that the criterion of the public interest is rigorously applied to such planning and organization.

In the majority recommendation a distinction is made between the regulatory bodies whose registrants are "university prepared" and those who are dealing with people educated or trained in non-university settings. The former, my colleagues believe, should retain their powers of self-government subject to the surveillance of an overseeing body while the latter should lose such powers if they presently enjoy them or be considered ineligible to receive such powers in the future. To assume the regulatory function for bodies which may not have self-regulatory powers there would be established a Health Disciplines Regulation Board with a division for each discipline.

It seems to me that if the surveillance of an overseeing body can safeguard the public interest in the relatively complex operations of the "university-prepared" disciplines, where the determination of what *is* in the public interest is sometimes a very difficult matter, then it can much more easily do so in the case of the "non-university prepared" disciplines; and this consideration coupled with our findings in studying the operations of all these regulatory bodies, that there was no more cause to criticize the one category of disciplines than the other, suggests to me that the proposed structure is unnecessarily complex. I would recommend that disciplines which are now self-regulated should remain so and future applications for self-regulatory powers from new groups should be considered on their merits. There should be established a Health Disciplines Regulatory Board as a division of the Ontario Health Services Commission, but its primary responsibility would be to exercise surveillance over the operations of the self-regulatory bodies and over proposed changes in legislation, regulations or by-laws which would affect them. It would assume the regulatory function itself only in cases where self-regulation was considered inappropriate or temporarily impracticable. I believe that had there existed in the past such a body with these responsibilities there would have been very little cause for complaint today about self-regulation of any of these disciplines and that the establishment of such a body makes unnecessary other measures which might have been considered desirable in the public interest.

For this reason, I am doubtful about the recommendations that representatives of the public be added to all these regulatory bodies. It would be very difficult to find the number of appropriate people to serve on these boards, and their presence

as minorities on the boards could give a misleading impression of public participation in the regulation of these disciplines. I believe that the purpose is accomplished by the establishment of the Health Disciplines Regulatory Board and that this additional measure might well be considered unnecessary interference with self-government. I do not believe that it would be harmful, and there may be cases in which it would be useful and helpful, but I do not believe that it is necessary from the point of view of ensuring that the actions of these bodies are consistent with the public interest.

Two other proposals made in Chapter 25 with which I am in complete disagreement deal with the control of education and of continuing education and are stated in Recommendations 317 and 322. I am aware that in the case of such bodies as the College of Physicians and Surgeons of Ontario and of the Royal College of Dental Surgeons of Ontario such powers as it is recommended in 317 should now be taken from them they have long since delegated to other bodies. There is, however, in my opinion, some reason to question whether in doing so they have not neglected their duty to the public, and there are very strong reasons why they should retain their statutory powers to control education and should consider a more active use of them.

We have seen in Chapter 3 why it was considered necessary to create such bodies which would be responsible for the standards of competence in the professions and why they were given powers to determine the competence of applicants to enter the professions. In other countries substitutes have been found for such professional regulatory bodies in the form of state examining boards, or similar organizations, but no such proposal is made here. These boards are to remain the arbiters of professional competence responsible to the public for the standard of competence of the profession and the individuals whom they license. I believe that as long as they have those responsibilities they must have authority to determine standards of competence which must be attained by applicants for admission to practice which means, in effect, they must be able to say what will be taught to students and to what standards. They may delegate these powers and the authority to examine applicants if they wish, but they remain responsible to the public for the proper exercise of them by the bodies to which they have been delegated.

The responsibility for continuing education which by Recommendation 322 would be assigned to the educational institutions might appear to be a new responsibility which has not in the past been delegated explicitly to any body. That is, of course, not really the case because, as is pointed out in Chapter 25, a regulatory body which is responsible for competence in a discipline is responsible for continuing competence and so, to the degree that continuing competence is dependent on continuing education, regulatory bodies have been responsible for continuing education. This was generally acknowledged by such bodies with whom this question was discussed in our hearings, and equally generally it was acknowledged that it was a difficult problem and that too little had been done about it in the past.

This responsibility, I believe, must be retained by the regulatory bodies which should not be put in the position of discharging their responsibility for the competence of their licentiates or certificants by accepting from the educational institution a certificate that the individual has demonstrated that his competence continues to meet standards established by the educational institution. Here again, the regulatory bodies may delegate their responsibility to establish curricula, standards, and methods of determining that standards are maintained, but they must remain responsible for their performance and it would seem most desirable, particularly initially, that the delegation should not be too extensive and the participation of the regulatory bodies should be an active one.

The argument for the transfer of control of health care education to educational authorities is developed in Chapter 26 after a discussion of "the kind and amount of education required"; and so I will deal with these and the other points on education in the order that they are discussed in that chapter.

Education

Although there is no explicit statement in the discussion of "kind and amount of education required" of a conclusion favouring a broadening of the general education content of health care courses, the conclusions regarding the control of education and the institutions preferred for the location of courses seem to suggest an inclination to favour broader curricula.

I believe that a clear statement to the contrary should be made, emphasizing that, because of the shortage of supply of many important health services and the increasingly apparent limitations on the resources, however much we may favour a move in the direction of broader education and freer choice of education and career, we are forced to the conclusion that for the present the resources must be applied to producing the optimum output of services and of the people required to render these services. I think that it would be very difficult to justify any other conclusion when so little is known about the contribution to competence of broadened general education, or the effect that it would have on recruitment and on the cost of education and of delivering the service. These imponderables should be the subjects of experiment and studies when it is considered possible to relax this policy and to entertain proposals for more comprehensive curricula.

An orderly development of the answers to this question "kind and amount of education required" is one of the processes and one of the objectives of developing a health services system. I believe that the roles of the various disciplines should be re-examined in the light of the present and predictable requirement for services, and the education in each discipline should be tailored to the role. This means that the answer to the question would be "the kind and amount of education required for the performance of the role" with, of course, the important reservation that provision must be made for the higher educational needs of teachers and possibly administrative and supervisory personnel. This does not mean that the

curricula would be as close to the vocational as possible. A broad interpretation should be put on "performance of the role" but the value judgment should not be made by educationists alone.

This process of review of role and education by an Educational Committee of the Health Services Commission or of the Ontario Council of Health would draw attention to cases of overeducation or the neglect of preparation for certain aspects of the practice such as are referred to on page 94, this in fact being the process of "convincing outsiders" referred to on the same page.

On the question of the completeness of the education as a preparation for practice, it seems that there has been for some years a trend towards the position that this should not be a requirement of the education and I believe that any extension of this trend should be discouraged for the same reasons that I think the education must be tailored to the role. Apart from other considerations it seems to me that if the pattern should be adopted that licensing or certified bodies must automatically license or certify the graduate of the educational institution, then this change, in association with the above trend, would produce an important change in the significance of licensure or certification. Whether this change takes place or not, confusing situations have arisen and will continue to arise and I would suggest the public interest is best served if such situations be recognized and clarified by the granting of licensure or certification conditional on the completion of the required period of training. A case in point is dentistry. House[1] and other authorities tell us that the dental graduate is not really equipped with all the skills required to practise and yet on graduation he is free to do so. In nursing also we are told that the graduates of certain courses really require some months of practical experience before they are as competent as the graduates of other courses. I think that it is preferable that the practical training be taken concurrent with, and as part of, the education prior to graduation; but where this is not possible, or at any rate is not done, the situation should be recognized and the requirement be made explicit.

I believe that if the principle is accepted that for all bodies and individuals working in this broad field of health care the primary consideration must be that the public receives the services that they require to the full extent that the resources permit, then the answers to the questions which are raised about educational administration become relatively simple. The basic structure in the field of health care is the delivery system, the purpose of which is to ensure the optimum availability of services, and the health care educational system, if it can be so described, must base its planning on supplying the requirements of the delivery system. The body responsible for coordinating the delivery system will look to each discipline to provide its services, adequate in quality and quantity, which means that there must be in each discipline an organizational structure which can

[1]R. K. House, *Dentistry in Ontario,* Committee on the Healing Arts, Queen's Printer, Toronto, 1970.

assume this responsibility. These are the colleges and boards, the responsibilities of which we have been discussing. They were created for the primary purpose of safeguarding the public interest and their powers were given to them for that purpose. The public interest requires that each discipline makes available to the health care delivery system an adequate number of competent practitioners and the powers of the regulatory body should be used to that end. Failure to use the powers appropriately is neglect of the public interest.

Critics of our medical and dental schools and in fact of such institutions throughout North America, complain that they are research-oriented, disease-oriented and cure-oriented, and that their curricula and their methods of training are more appropriate to the production of researchers than practitioners. In particular, as a result of this orientation, it is complained that medical schools produce many more candidates for specialty courses than urgently needed general physicians, a question discussed in detail in Chapter 30.

Although there seems to me to be a good deal of evidence to support such views, clearly this Committee is not competent to evaluate alternative proposals for medical or dental curricula. That, in Ontario, is presently the responsibility of the professional regulatory bodies, the College of Physicians and Surgeons of Ontario and the Royal College of Dental Surgeons of Ontario, a responsibility which they have long since delegated to other bodies and which they would now yield permanently to these bodies if Recommendation 317 were to be adopted. I suggest that to the extent that there is validity in these criticisms, the regulatory bodies have been derelict in their duty to the public by failing to question the exercise of their powers by the bodies to which they had delegated them. It is not necessary to attempt to determine that extent. The fact that the critics could be right and that many knowledgeable people believe that they are is in my opinion adequate reason to reject the thought of removing the control of education from the regulatory bodies and rather to consider what measures might be taken to encourage them to reconsider the extent of the delegation of powers and their continued responsibility for their exercise. This kind of exercise would, of course, be prompted in the future by an Ontario Health Service Commission, if it found in the fulfilment of its responsibility to oversee the activities of the regulatory bodies that a regulatory body was remiss in this respect.

I am not reassured by the requirement of accreditation by external accrediting bodies nor the fact that medical graduates must sit the examination of the Medical Council of Canada because these are not new measures being introduced now as a substitute for the vigilance of the regulatory bodies. They have been part of the system responsible for the curricula, the appropriateness of which is now in question.

As we have said earlier, the educational requirement depends on the role; the determination of the role should be an interdisciplinary matter, but the determination of the education to fit the role should be made within each discipline by a body made up of practitioners, educationists, and representatives of interested

and knowledgeable groups such as related disciplines, employers and consumers. The same body should recommend the approval of schools, though it should not necessarily be the sole accrediting authority, and also the standards by which competence to practise will be determined, and the recommendations of this body on curricula, accreditation and standards, should be submitted to the regulatory body and become effective only with the approval of that body. Thus the regulatory body may do as many have done and entrust the planning of curricula, the operation of schools, decisions on admission standards for the schools, and examination of candidates to enter the practice to other bodies; but as we have said it must satisfy itself that these delegated powers are being exercised in the public interest for which it continues to be responsible.

It is argued that such powers over control of education, wielded by a body other than an educational body, may be, and in fact occasionally have been, abused to the prejudice of the interests of those who might wish to enter the profession or occupation, or the public in general. If courses became too vocational in character, then students would be deprived of a broad educational experience. This is something that might well happen under a pressure to provide more practitioners; but it is to be hoped that the voice of educationists in the planning of curricula would maintain an appropriate balance, and if it failed to do so to the point where the course became unattractive to prospective applicants, then declining enrolment would draw attention to the fault and make an adjustment necessary.

In the same way we would hope that any tendency to restrict admission to the occupation by excessive increase of educational standards would be checked within the discipline. But should this not be so, the presence of the Health Services Commission, with its responsibility to ensure that services are available, will mean that the performance of these regulatory bodies in the use of their powers will be under a surveillance which has not existed in the past, the absence of which is responsible for many of the problems which have been brought to our attention.

Special concern is expressed also about educational institutions operated by such employers as hospitals, and this extends to mandatory periods of practical experience in such institutions for students enrolled in other educational institutions, the fear being that such students are subject to exploitation by the employers who may prolong the practical training periods at the expense of the didactic content of courses in order to obtain the services of the students at substandard wages. There is no doubt that this danger exists and that such exploitation has taken place, but I do not believe that the remedy is to do away with hospital-oriented educational and training courses and I am afraid that the proposal that the practical experience in hospitals of students attending other educational institutions should be under the control of the educational institution, will often be unworkable and create many more problems such as already exist between medical schools and teaching hospitals.

There can be no doubt that in this kind of relationship there is a nice point at which all concerned benefit. The hospital gets urgently needed help, the student gets necessary experience while being paid, and the public receives services which otherwise might not be available. There is nothing inherently bad or unreasonable about the system, but again, there must be a control which has not existed in the past to ensure that it is not abused. The standards of accreditation of such institutions and the objectivity of the accrediting bodies must be reviewed and be subject to a continuing surveillance by bodies on which all concerned are represented, making their recommendations to the regulatory body which in turn would be under the surveillance of the Health Services Commission.

The proposals that are made in Chapter 26 under the heading "Location of Educational Programs" are aimed at the fulfilment of three main objectives: 1) the integration of all health care education into something resembling an educational system; 2) the placing of all health care education under education authorities of one level or another; and 3) the improvement of standards of didactic teaching which would be provided in institutions run by educational authorities. I certainly agree that there does not exist at present anything resembling an organized health care education system, but I do not believe that the advantages of having an integrated system justify the major changes required to produce one. As I have said before, a more highly organized system is essential for the *delivery* of health services, and out of this system will come clearer definition of roles and educational requirement. This being the case, it seems to me that there is no real need for the educational institutions to be integrated into an educational system to supply the required education and to produce the people required for the delivery system. The educational and training institutions may be part of the delivery system, as some now are, or part of the educational system as others are, or may be detached entities or may be run by the individual disciplines, and, as is the case at present, candidates for practice in some disciplines may be forthcoming from both educational system and delivery system sources. Much of the case for the development of more "systematic" health care education seems to be based on theoretical advantages which are slow to materialize and for some of which hope has already been abandoned. In fact there are few arguments in its favour which are based on actual experience of favourable results.

The arguments for control of health care education by educationists we have already discussed, but while I am opposed to this, there is certainly no objection to the location of courses in educational institutions so long as this does not require a shift of control nor involve the actual or projected phasing out of present institutions until the quality and quantity of the product of the new courses can be assessed. There are many disciplines in need of supplementary sources of manjower. Experiments to develop these sources in educational institutions such as the Colleges of Applied Arts and Technology should certainly be considered, but in the initial stages such developments should be regarded as experimental and supplemental, to become permanent if successful, but not necessarily to become a substitute

source completely replacing the original source. I would strongly recommend that, on this basis, solutions to present manpower problems should be evolved which would require contributions from the educational system not only to the quantitative output but, by cooperation with training institutions, through the provision of didactic courses, to the quality of the output.

May I say in conclusion that in the solution of problems such as are discussed in these three chapters, there is merit in keeping the changes as few and simple as possible. This is particularly desirable at a time when uninterrupted and increased efforts are required from the institutions under study. I believe that the recommendations in these chapters go further than is necessary and as a result create some very complex relationships. This complexity is reflected by the need which is seen by my colleagues for the creation of a Cabinet Coordinating Committee and subcommittee. I do not believe that such bodies will be able to replace effectively the close relationship between suppliers of health care services and suppliers of health care personnel which is so desirable if the available health care resources are to provide the optimum output of health care services.

Because I hold the opinions expressed above I am unable to agree with any recommendations in this Report which involve the Department of Health's assuming responsibilities for the development of the health care services system or the transfer of the control of education from the professional or occupational regulatory bodies to educational bodies.

I. R. Dowie

Minority Opinion on Chapter 28, Patterns of Mental Health Care

Regardless of whatever actions may be taken in connection with the recommendations made in Chapter 24 or in the minority opinion on administration and planning, I strongly recommend that there should be established immediately an advisory body to be known as the Ontario Council of Mental Health to perform in the area of mental health the same role as the Ontario Council of Health performs in all health matters, of advising whatever administrative body is charged with the responsibility of ensuring that the public receives the health care services that it requires.

It will be clear to anyone who has read Chapters 13 and 28 that this administrative body is going to have to pay particular attention to the delivery of mental health care services because in this area more than any other that we have examined there is evidence of the inadequacy of services, both qualitatively and quantitatively. Major programs to improve these services are obviously needed and happily, as we have said, a start has been made upon them; but to complete them a very great increase will be required in the production of skilled practitioners at every level of skill, from psychiatrists to psychiatric nurses and child care workers.

If, as seems likely, one of the heaviest burdens on the planners is the mental health care problem, then it is particularly necessary that they be well advised in this area, and I would suggest that the Ontario Council of Mental Health, which could be a smaller body than the Ontario Council of Health, should be of similar composition, with the exception that among the professional representatives a majority should be selected from mental health professions.

Any proliferation of specialized Councils of Health should certainly be avoided, but the case of mental health seems to be unique in that the development of the knowledge appears to have lagged behind that of other fields of medicine so that much research is required as well as much experimentation to determine the most effective and efficient way of making mental health care services available to those who require them.

In Chapter 8 we have discussed the neglect of psychiatry in undergraduate medical school curricula until recent years. This circumstance and the fact that in Ontario, until recently, much of the postgraduate education and training of psychiatrists has been centred in the Ontario Hospitals rather than in general hospitals, have contributed to a situation which justifies questioning the level of

understanding of mental health care problems and the amount of attention paid to them by physicians who are not presently active in that field.

This suggests to me that, at least for the present, until mental health care programs in Ontario catch up with other health care programs in terms of meeting the needs, a special group of expert advisers concentrating their attention on this area would be very helpful to the provincial health care planning and administrative body.

I. R. Dowie

Minority Opinion on Chapter 30, The General Physician

I agree with the analysis and statement of the problem of the growing shortage of general physicians as stated in Chapter 30, but disagree with some of the proposals made in Recommendations 349, 351 and 352.

I agree that ways must be found to reduce the flight from general to specialty practice and to increase the percentage of medical school graduates selecting general practice as the field which they want to enter. To achieve these objectives it will be necessary to improve the lot of the general practitioner with regard to working conditions, remuneration and professional status relative to those enjoyed by his specialist colleagues, and to reform what is referred to as the "educational milieu" which it is generally agreed is at present likely to discourage a student from pursuing his intention to enter general practice, and to make the pursuit of a specialty seem to be a much more rewarding alternative.

It is agreed also that the very extensive changes in conditions which have taken place during the last half century, and more particularly in recent years, make it most desirable that the whole concept of the general practitioner and his education should be reviewed with a view to providing the highest possible standards of health care services at the "first contact" level. Any measure recommended for the achievement of any of these objectives should contemplate the others and should be evaluated on the basis of the contribution which it makes to the improvement of the general situation and not simply to one aspect of it.

I am unable to agree with Recommendation 349 because it involves specialist status in the field of "family medicine" and assumes that an extension of the educational term is necessary. Both have negative aspects which I believe make this solution to the problem unacceptable.

It is argued by many medical educational authorities that the "knowledge explosion" has made it impossible to continue to produce a competent generalist in the four years of the professional course plus the one year of internship; but others feel that, in view of the pressures of the competition of alternative careers and the urgent demand for new graduates, this is not a realistic approach to the problem. Those who oppose extention of the period of education believe that what is required is simply a revision of the curriculum which will take into consideration the fact that the "knowledge explosion" has increased, both in width and depth, the field covered by specialists and practitioners in developing subspecialties, thus increasing substantially the resources available to the general

physician by the referral of patients. In their view the present curriculum is more appropriate for the undergraduate studies of those who will proceed to postgraduate studies than it is to the qualification of graduates who will enter immediately into the general practice of medicine. This view is expressed by Clute[1] and it was a subject of discussion at the Fort Lauderdale Conference on "The Crisis in Medical Services and Medical Education," February 20-25, 1966, at which it was suggested that the medical course could be shortened without sacrifice of improved quality. "One hope for medical education lies in transferring to the undergraduate (pre-medical) years some of the instruction in basic sciences now required in medical school. Such a transfer is becoming feasible because of the curriculum reform movement which has strengthened teaching in mathematics and the sciences throughout the educational system. The movement began in the high school a dozen years ago and the full effects began to hit the colleges three or four years ago. Medical students are already entering their first year with collegiate backgrounds in biochemistry and other basic sciences equivalent to the level of instruction offered in the beginning medical curriculum."

Dr. J. Gershon-Cohen[2] goes still further saying that "the length of the physician's education is central to the dilemma" and proposing a plan for reduction of the period required for medical education, which excited great interest when it was presented at the hearings before the subcommittee on Public Health and Welfare of the Committee on Inter-State and Foreign Commerce, House of Representatives 90th Conference, June 11-13, 1968. In this presentation it was suggested that a general physician could be produced in five years following graduation from high school including as the fifth year a mandatory internship in a general practice setting. This has to be compared with the general U.S. pattern of four years of pre-profession college, four years of medicine and one year internship. This would be accomplished by accommodating in senior high school curricula some of the basic science courses. Proposed also by Dr. Gershon-Cohen was a new type of medical school which would produce general practitioners only, although they would be qualified to proceed into specialization if they wished.

Clearly it is not within our competence to evaluate such a proposal, but it certainly does suggest that there may be solutions to the problem which do not require the extension of the education at a time when a reduction is so obviously desirable and when the Minister of Health of Ontario, a physician, was moved to invite medical schools to consider ways in which their output of graduate physicians could for a few years be substantially increased.

The concept of specialist status in the field of general practice is a concession to the impact of the "knowledge explosion" but also, and perhaps more importantly, to the problem of making general practice more attractive to the prospective

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[1]K. F. Clute, *The General Practitioner,* University of Toronto Press, Toronto, 1963, p. 486.

[2]Dr. J. Gershon-Cohen, M.D., D.Sc. (Medicine), Director Emeritus, Division of Radiology, Albert Einstein Medical Center; Professor of Research Radiology, Temple University School of Medicine.

graduate. Recommendations 349 and 352 which urge that special attention be given to the improvement of the income expectancy and the status in the profession of such specialists clearly have the same purpose in mind.

How effective these measures might be in making general practice more attractive to the medical student it is hard to say, but clearly they would not contribute in any way to solving the problems of the man who is already engaged in general practice at the non-specialist level. On the contrary they may well speed the flight of such practitioners into specialties, if they cause them to feel that the establishment of specialist status recognizes two levels of medicine in family practice — a recognition emphasized by the fee schedule and hospital privilege provisions of Recommendations 351 and 352.

In my opinion all reference to specialist status should be dropped from these two recommendations, and they should refer to all physicians engaged in general practice. Greater emphasis should be placed on the reformation of curricula and of "medical school milieu" and on the measures proposed in Recommendation 353 to improve the "working conditions" of general practitioners.

There is a great urgency to solve this problem, and I would recommend that medical schools be encouraged to give it very serious study and to give top priority to initiating, possibly experimentally, measures to increase the output of general practitioners. Particular encouragement should be given to McMaster University where present planning seems to offer considerable promise in this respect, and to those entrusted with the planning of the sixth Ontario medical faculty, the establishment of which we discuss and recommend in Chapter 8.

I. R. Dowie

APPENDIX I

Counsel to the Committee
Julian Porter

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APPENDIX II
Appended Volumes

Dentistry in Ontario	R. K. House
A Legal History of Health Professions in Ontario	Elizabeth MacNab
Mental Health in Ontario	C. Hanly
Nursing in Ontario	V. V. Murray
Organized Medicine in Ontario	J. W. Grove
The Paramedical Occupations in Ontario	Oswald Hall
Private Clinical Laboratories in Ontario	Chemical Engineering Research Consultants Ltd.
Sectarian Healers and Hypnotherapy	John A. Lee
Selected Economic Aspects of the Health Care Sector in Ontario	R. D. Fraser
Social Work in Ontario	M. Landauer

APPENDIX III

Public Hearings of the Committee on the Healing Arts

Organizations

Association of Remedial Gymnasts of Ontario[1]
Board of Directors of Chiropractic[1]
Board of Directors of Drugless Therapy[1]
Board of Directors of Masseurs[1]
Board of Directors of Osteopathy of Ontario[1]
Board of Directors of Physiotherapy[1]
Board of Ophthalmic Dispensers[1]
Board of Radiological Technicians[1]
Board of Regents, Chiropody Act[1]
Brown Camps Inc.[1]
Canadian Arthritis and Rheumatism Society (Ontario Division)[1]
Canadian Association of Electroencephalograph Technicians[1]
Canadian Association of Occupational Therapists[1]
Canadian College of Massage and Hydrotherapy[1]
Canadian Council for Supervised Pastoral Education[1]
Canadian Council of Hospital Accreditation
Canadian Dietetic Association[1]
Canadian Hearing Society[1]
Canadian Memorial Chiropractic College[1]
Canadian Natural Hygiene Society[1]
Canadian Psychoanalytic Society
Canadian Section of the National Federation of Spiritual Healers[1]
Canadian Society of Clinical Chemists[1]
Canadian Society of Laboratory Technologists[1]
Church of Christ, Scientist[1]
Church of Scientology, Toronto
College of Family Physicians of Canada
College of Nurses of Ontario[1]
College of Optometrists of Ontario[1]
College of Physicians and Surgeons of Ontario[1]

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[1]Also submitted briefs to the Committee on the Healing Arts.

Commission on Emotional and Learning Disorders in Children[1]
Committee of Presidents of Universities of Ontario
Dental Laboratories Association of Ontario[1]
Department of National Defence, Surgeon General's Office
Doctors Clinical Laboratory[1]
Governing Board of Dental Technicians of the Province of Ontario[1]
Homoeopathic Laymen's League of Toronto[1]
Medical Alumni Association, University of Toronto[1]
Motivation Study Association[1]
Ontario Association for Children with Learning Disabilities[1]
Ontario Association of Dispensing Opticians[1]
Ontario Association of Massage Therapy[1]
Ontario Association of Medical Clinics[1]
Ontario Association of Medical Record Librarians[1]
Ontario Association of Professional Social Workers[1]
Ontario Association of Registered Nursing Assistants[1]
Ontario Board of Examiners in Psychology[1]
Ontario Branch of the Canadian Physiotherapy Association[1]
Ontario Cancer Treatment and Research Foundation[1]
Ontario Chiropractic Association[1]
Ontario College of Pharmacy[1]
Ontario Dental Association[1]
Ontario Dental Hygienists' Association[1]
Ontario Department of Education[1]
Ontario Dietetic Association[1]
Ontario Hearing Aid Association[1]
Ontario Hospital Association[1]
Ontario Hospital Services Commission[1]
Ontario Medical Association[1]
Ontario Naturopathic Association[1]
Ontario Osteopathic Association[1]
Ontario Pharmacists Association[1]
Ontario Podiatry Association[1]
Ontario Psychiatric Association[1]
Ontario Psychological Association, Inc.[1]
Ontario-Quebec Region of the Association of Mental Health Chaplains[1]
Ontario Society of Medical Technologists[1]
Ontario Society of Oral Surgeons[1]
Ontario Society of Physiotherapy[1]
Ontario Society of Radiological Technicians[1]
Ontario Speech and Hearing Association[1]
Optometrical Association of Ontario[1]

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[1]Also submitted briefs to the Committee on the Healing Arts.

Patients Committee of the Hyland Institute[1]
Pharmaceutical Manufacturers Association of Canada[1]
Planning Committee for the Proposed Toronto Institute for Training in the Technological aspects of Laboratory Medicine[1]
Prescription Services Incorporated[1]
Psychiatric Nurses Association of Ontario[1]
Registered Nurses' Association of Ontario[1]
Royal College of Dental Surgeons of Ontario[1]
Sault Ste. Marie and District Group Health Association and St. Catharines Group Health Centre[1, 2]
Select Optical Service Ltd.[1]
Society of Registered and Remedial Masseurs of Ontario[1]
St. John's Ambulance (Ontario Council)[1]
Sudbury District Medical Society[1, 2]
Toronto and District Labour Committee for Human Rights[1]
Toronto Institute for Pastoral Training[1]
University of Toronto Faculty of Dentistry[1]
University of Toronto Faculty of Food Science[1]
University of Toronto Faculty of Medicine[1]
University of Toronto Faculty of Pharmacy[1]
University of Toronto School of Nursing[1]
University of Waterloo School of Optometry[1]
University of Western Ontario School of Nursing[1]
Victorian Order of Nurses (Ontario Council)[1]

Individuals

Avery, Florence I.[1]
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Cowan, Shirley[1]
Forsey, H. R. and E. Q.
Hayward, L. D.[1]
Moodie, Dr. C. A.[1]
Van der Meer, W. A., Township of Michipicoten[1, 2]
Westlake, W. G.[1]
Wilcox, Dr. L. D.[1]
Young, Dr. Murray

Briefs Received by Committee on Which No Hearing Was Held

Congress of Canadian Women
Hartleib, C. J.
Keen, Mrs. M.
Tonken, Dr. Harvey

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[1]Also submitted briefs to the Committee on the Healing Arts.
[2]Hearing held in Sault Ste Marie, Ontario.

APPENDIX IV

Appearance at the Request of the Committee and Visits by Members of the Committee

American Hospital Association, Chicago, Illinois.
American Medical Association, Chicago, Illinois.
Association of Canadian Medical Colleges (Ottawa).

British Postgraduate Medical Federation, London, England.
Bush, Dr. J. W., Assistant to the Executive Director, Health Planning Commission, New York, N.Y.
Byng, Dr. Peter, National Advisory Commission on Health Manpower, Washington, D.C.

Canadian Memorial Chiropractic College, Toronto, Ontario.
Campello, Dr. Carlos, Dean of Medical School, University of Mexico.
Cashman, J. P., Ministry of Health, London, England.
Central Midwives Board, London, England.
Chamberlain, Dr. Joyclen, Guy's Hospital, London, England.
Clute, Dr. K. W., Department of Health Administration, School of Hygiene, University of Toronto.
Columbia Point Community Health Clinic, Boston, Massachusetts.
Committee on University Affairs (Ontario).

Dale, Dr. B. T., Medical Officer of Health and Director, Wellington-Dufferin-Guelph Health Unit, Guelph Office.
Dean, Dr. C. Robert, Associate Regional Health Director, Program Development, New York, N.Y.

General Medical Council, London, England.
General Optical Council, London, England.
Godber, Sir George, Ministry of Health, London, England.

Hacon, Dr. William S., Director of Health Resources, Department of National Health and Welfare, Ottawa.

Keene, Dr. Clifford.
Kissick, Dr. William L., Professor and Chairman, Department of Community Medicine, School of Medicine, University of Pennsylvania, Philadelphia.

LaCroix, Chief Justice Gerald, Quebec City, P.Q.

McCreary, Dr. John F., Dean of Faculty of Medicine, University of British Columbia, Vancouver, B.C.
McKay, Miss M., Health Planning Branch, Office of Comprehensive Planning, Bethesda, Maryland.
Medical Research Council, Ottawa.
Miles Square Neighbourhood Health Centre, Chicago, Illinois.
Ministry of Health, London, England.

National Advisory Commission on Health, Washington, D.C.
National College of Chiropractic, Lombardy, Illinois.
North Lawndale Neighbourhood Health Centre, Chicago, Illinois.

Office of Comprehensive Health Planning, State of North Carolina, Raleigh, N.C.
Ohio College of Podiatry, Cleveland, Ohio.
Ontario Deans of Medicine.
Ontario Department of Health.

Palencia, Dr. Luis, Department of Preventitive Medicine, Faculty of Medicine, University of Mexico.

Quebec Health and Welfare Inquiry Commission.

Reid, Dr. Grainger, Director of Research and Planning Branch, Ontario Department of Health.
Roth, Dr. F. Burns, Chairman, Department of Health Administration, School of Hygiene, University of Toronto.
Royal College of Physicians and Surgeons of Canada (Ottawa).

Saward, Dr. E. W., Medical Director, Kaiser Foundation Hospital, Portland, Oregon.
South Side Neighbourhood Health Clinic, Chicago, Illinois.

Tapsfield, J. S., Registrar, The Council for Professions Supplementary to Medicine, London, England.
Taylor, of Harlow, The Rt. Hon. Lord, President, Memorial University of Newfoundland, St. John's, Nfld.
Tulchinsky, Dr. T. H., Medical Director, Community Group Health Foundation, St. Catharines, Ontario.

Workmen's Compensation Board, Ontario Department of Labour.

Young, Dr. Murray, Director of Laboratories, Toronto General Hospital.

APPENDIX V

Organizations Completing Questionnaires for the Committee on the Healing Arts

Regulatory or Licensing Bodies in the Health Sciences

Board of Directors of Drugless Therapy
Board of Directors of Masseurs
Board of Directors of Osteopathy
Board of Directors of Physiotherapy
Board of Ophthalmic Dispensers
Board of Radiological Technicians
Board of Regents, Chiropody Act, 1944
Canadian Section of the National Federation of Spiritual Healers
Church of Christ, Scientist
College of Nurses of Ontario
College of Optometrists of Ontario
College of Physicians and Surgeons of Ontario
Medical Council of Canada
Ontario Board of Examiners in Psychology
Ontario College of Pharmacy
Ontario Dietetic Association
Royal College of Dental Surgeons of Ontario
Royal College of Physicians and Surgeons of Canada
Spiritualist National Union of Canada
United Spiritualist Church of Ontario

Voluntary Associations in the Health Sciences

Academy of Medicine, Toronto
Canadian Anaesthetics Society
Canadian Association of Electroencephalograph Technicians
Canadian Association of Occupational Therapists
Canadian Association of Optometrists
Canadian Chiropractic Association
Canadian Dental Association
Canadian Dietetic Association

Canadian Institute of Psychoanalysis
Canadian Nurses' Association
Canadian Physiotherapy Association
Canadian Psychoanalysis Society
Canadian Society of Clinical Chemists
Canadian Society of Inhalation Therapy
Canadian Society of Laboratory Technologists
College of Family Physicians of Canada, Ontario Chapter
(formerly the College of General Practice of Canada)
Committee of Toronto Medical Libraries Group
Dental Laboratories Association of Ontario
Ontario Association of Dispensing Opticians
Ontario Association of Medical Record Librarians
Ontario Association of Pathologists
Ontario Association of Professional Social Workers
Ontario Association of Registered Nursing Assistants
Ontario Chiropractic Association
Ontario Dental Hygienists Association
Ontario Dental Nurses and Assistants Association
Ontario Medical Association
Ontario Naturopathic Association
Ontario Osteopathic Association
Ontario Pharmacists Association
Ontario Podiatry Association
Ontario Psychiatric Association
Ontario Psychological Association, Inc.
Ontario Society of Medical Technologists
Ontario Society of Occupational Therapists
Ontario Society of Physiotherapy
Ontario Society of Radiological Technicians
Ontario Speech and Hearing Association, Inc.
Optometrical Association of Ontario
Practising Hospital Pharmacists in Ontario
Registered Nurses' Association of Ontario
Royal College of Dentists of Canada

Educational Institutions in the Health Sciences

Branson Hospital School of Nursing (Metropolitan Toronto)
Brantford General Hospital Department of Radiology
Brantford General Hospital School of Medical Laboratory Technologists
Brantford General Hospital School of Nursing
Canadian College of Massage and Hydrotherapy (and its affiliate Canadian Institute of Parapak Therapy)

Canadian Memorial Chiropractic College
Canadian Mothercraft Society
Chicago College of Osteopathy
College of Optometry of Ontario
College of Osteopathic Medicine and Surgery, Des Moines, Iowa
Cornwall General Hospital School of Nursing
Fort William School of Radiological Technicians (McKellar General Hospital)
Hamilton Civic Hospital School of Nursing
Hamilton and District School of Nursing
Hospital for Sick Children School of Nursing (Toronto)
Hôtel Dieu School for Medical Record Librarians (Kingston)
Kansas City College of Osteopathy and Surgery
Kingston General Hospital School of Nursing
Kirksville College of Osteopathy and Surgery
Mack Training School for Nurses, St. Catharines General Hospital
McKellar General Hospital School of Medical Technology (Fort William)
McMaster University College of Health Sciences
McMaster University School of Nursing (Hamilton)
Metropolitan General Hospital School of Nursing (Windsor)
Nightingale School of Nursing
Ontario Association of Medical Record Librarians
Ontario College of Massage
Ontario Department of Health Registered Nursing Assistant Program
Ontario Hospital School of Nursing (Kingston)
Ottawa General Hospital School of Nursing
Peterborough Civic Hospital School of Nursing
Plummer Memorial Public Hospital and School of Nursing (Sault Ste. Marie)
Public General Hospital School of Nursing (Chatham)
Queen's University Faculty of Medicine
Queen's University School of Nursing
Quo Vadis School of Nursing
Regional School of Medical Laboratory Technology (London)
Ryerson Polytechnical Institute
St. Elizabeth School of Nursing (Sudbury)
St. John Ambulance (Ontario Council)
St. Joseph's Hospital School of Nursing (Hamilton)
St. Joseph's Hospital School of Nursing (London)
St. Joseph's School of Nursing (Cornwall)
St. Joseph's School of Nursing (Peterborough)
St. Joseph's School of Nursing (Windsor)
St. Mary's School of Nursing (Sault Ste. Marie General Hospital)
St. Michael's Hospital School of Medical Record Librarians (Toronto)
St. Michael's Hospital School of Nursing (Toronto)
St. Thomas-Elgin General Hospital

Stratford General Hospital School of Nursing
Thistletown Hospital School for Child Care Workers
Toronto General Hospital
Toronto General Hospital School of Nursing
Toronto Institute for Pastoral Training
Toronto Institute for Training in the Technological Aspects of Laboratory Medicine
Toronto Western Hospital Atkinson School of Nursing
University of Ottawa Faculty of Medicine
University of Ottawa School of Nursing
University of Ottawa School of Social Welfare
University of Toronto Faculty of Dentistry
University of Toronto Faculty of Food Sciences
University of Toronto Faculty of Medicine
University of Toronto Faculty of Pharmacy
University of Toronto School of Hygiene
University of Toronto School of Nursing
University of Toronto School of Social Work
University of Western Ontario Faculty of Dentistry
University of Western Ontario Faculty of Medicine
University of Western Ontario School of Nursing
University of Windsor, Ontario School of Nursing
Victoria Hospital (London)
Victoria Hospital School of Nursing (London)
Woodstock General Hospital School of Nursing

Hospitals in Ontario (a Selected Sample)

Brantford General Hospital
General Hospital of Port Arthur
Greater Niagara General Hospital
Hamilton Civic Hospital
Hamilton General Hospital
Henderson General Hospital (Hamilton)
Hôtel Dieu Hospital (Kingston)
Hospital for Sick Children (Toronto)
Kingston General Hospital
McKellar General Hospital (Fort William)
Metropolitan General Hospital (Windsor)
Misercordia Hospital (Haileybury)
New Mount Sinai Hospital (Toronto)
Oshawa General Hospital
Orillia Soldiers' Memorial Hospital
Ottawa Civic Hospital

Ottawa General Hospital
Peterborough Civic Hospital
Princess Margaret Hospital (The Ontario Cancer Institute)
St. Catharines General Hospital
St. Joseph's Hospital (London)
St. Michael's Hospital (Toronto)
St. Thomas-Elgin General Hospital
St. Vincent Hospital (Ottawa)
Sault Ste. Marie General Hospital
South Waterloo Memorial Hospital
Stratford General Hospital
Sudbury Memorial Hospital
Toronto East General and Orthopaedic Hospital
Toronto Western Hospital
Wellesley Hospital
Women's College Hospital
Woodstock General Hospital

Private Laboratories in Ontario

Brampton Cytology Services
Brampton Medical Laboratory Limited
Clinical Investigation Laboratories
Clinical Laboratories Limited (Kitchener)
Clinical Pathology Laboratory
College Laboratory
Comprehensive Medical Laboratories
Cyto-pathology Associates
Cyto-pathology Consultants
Dr. Peter Rado Laboratory
Doctors Clinical Laboratory
Don Park Laboratories
Haematology Services Limited
Hamilton Clinical Laboratory Services
Hamilton Medical Laboratory Limited
Kopp Clinical Laboratories
London Medical Laboratory
Medical Arts Laboratory, (Barrie)
Medical Arts Laboratory (Niagara Falls)
Medical Diagnostic Laboratory
Pathologists Services
Quality Medical Laboratory Services Limited
Radioactive Isotope Laboratory
Sculac Medical Laboratory Limited

Specialized Biochemistry and Medical Laboratory
Stuparyk Medical Laboratory
Sudbury Bio-Assay Laboratories Limited
Toronto Medical Laboratories Limited
Winter Laboratories
Zifkin Biological Laboratory Limited